State of Colorado

Medicaid Mental Health Capitation and Managed Care Program

Proposal for Section 1915(b) Capitated Waiver Program Renewal

Submitted by the Department of Health Care Policy and Financing and the Department of Human Services

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Introduction

The State of Colorado is requesting renewal of its existing 1915(b) waiver to continue to operate the Medicaid Mental Health Capitation Program. The waiver was initially approved by the Health Care Financing Administration in 1993 and has been renewed twice since the program was implemented in 1995.

The RFP2000 is frequently quoted in this waiver renewal as it was in the last. In April, 2000, the statewide Medicaid Mental Health Capitation program was bid under the parameters of the RFP2000 and the State's procurement rules. The RFP2000 has been incorporated into the contracts of the contractors that were selected to deliver the program's services.

In this waiver renewal, many of the documents that would have been included as attachments have already been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). As such, we have not included them in the interest of reducing the bulk of this document. We have, however, referenced them in the appropriate sections and they are available upon request from CMS or from our office at Mental Health Services.

In those sections of the waiver renewal where we provide narrative, if there is a change from the previous waiver, the text that is new or has been modified will be highlighted. Any programmatic changes in the upcoming waiver period will be noted with a double asterisk (**) and the text describing the change will also be highlighted. Since the bulk of the program will be unchanged in the upcoming waiver period, changes and additions are minimal.

Section A. General Impact

I. Background

Administrative Organization

The Colorado Medicaid Program is organizationally located in the Department of Health Care Policy and Financing. This agency is the single state agency authorized by the federal government to administer federal Medicaid funds.

Colorado Mental Health Services in the Department of Human Services is delegated authority to administer Medicaid funds for mental health services through a written Memorandum of Understanding with the Department of Health Care Policy and

Financing (HCPF). The Fiscal Year 2001 MOU between HCPF and Mental Health Services is contained in Attachment A.I.[1]

Prior to 1995, most Medicaid recipients in Colorado received mental health benefits through a fee-for-service system. Medicaid eligible individuals who were not enrolled in Health Maintenance Organizations (HMOs) received mental health services from a variety of Medicaid-enrolled providers, such as Community Mental Health Centers, clinics, hospitals, and private psychiatrists, psychologists and social workers. These health care providers billed the State Medicaid Program for each covered service provided to a Medicaid eligible consumer. There was no central gatekeeper determining the need for services and no single clinician or case manager coordinating all aspects of an individual's mental health care. Medicaid recipients were free to seek services from any Medicaid-enrolled provider.

Medicaid consumers who were enrolled in HMOs received a limited amount of inpatient and outpatient mental health services through these HMOs. Once an individual received the maximum mental health benefits available through the HMO, she/he received any additional necessary mental health services through the Medicaid fee-for-service system described above.

Federal Authority to Implement Managed Care Program

In 1993, the federal Health Care Financing Administration (HCFA) granted the State waivers under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act. These waivers allowed the State to implement a managed mental health program for a two-year period, beginning July 1, 1995 and ending June 30, 1997. These initial waivers were subsequently extended by HCFA through March 8, 1998.

In 1998, HCFA renewed the State's waivers for an additional two years, beginning March 9, 1998 and ending March 8, 2000. These waivers were subsequently extended by HCFA through April 9, 2001. In 2001, HCFA renewed the State's waivers for an additional two years beginning April 10, 2001 through April 9, 2003.

State Legislative Authority to Implement Managed Care Program

In 1992, the Colorado General Assembly passed House Bill 92-1306, authorizing the Departments of Human Services and Health Care Policy and Financing to implement a two-year pilot program to provide comprehensive mental health services to Medicaid beneficiaries through a capitated managed care system. In 1995, shortly before the start

[1] *Memorandum of Understanding (FY 2001) between Health Care policy and Financing (HCPF) and Mental Health Services (MHS). Attachment A.I.*

of the pilot program, the General Assembly passed Senate Bill 95-78, revising the reporting and termination dates of the pilot program and directing the Departments to implement a statewide mental health managed care program.

Implementation

The Colorado Medicaid Mental Health Capitation and Managed Care Program was implemented in 1995 in 51 counties, and in 1998 in the remaining 12 counties of the state. Eight contractors currently operate the Program. Each contractor operates the Program in a specific geographic area, and only one contractor operates in any given area. The State plans to continue to operate the program statewide throughout the period of this waiver renewal.

Stakeholder Involvement

Throughout the development of the program, the State has worked cooperatively with a variety of stakeholders. The program has been developed through a collaboration with the State's Mental Health Planning Council and its subcommittee, the Medicaid Capitation Program Advisory Committee. The development of the 1915(b) waiver included public comment periods that resulted in feedback from consumer groups, advocacy groups, direct service providers, contractors and community agencies.

Results of the Program

Colorado's mental health managed care program has resulted in a number of positive changes in the public mental health system, including:

- *the development of many new services (e.g. crisis beds, respite care, self-help groups, home based services, etc.) that are critical for appropriately treating persons with mental illness, but were not reimbursed under the Medicaid fee-for-service system;*

- *expansion of existing community-based services;*

- *a shift in services away from the most restrictive inpatient hospital services to less restrictive community-based services for those consumers who do not need the level of services provided in an inpatient setting;*

- *increased involvement and empowerment of consumers and families;*

- *steps towards development and implementation of a Recovery Model of care, such as development of consumer driven and consumer run services, leadership training for consumers, and increased opportunities for consumer employment within the mental health system;*

- *improved coordination of mental health services;*

- *creation of an independent Ombudsprogram; and*

- *cost savings for the State and Federal governments and increased control over future cost increases.*

The State is pleased with the results of the Program to date, but believes there are numerous opportunities to continue to improve the Program and the public mental health system in Colorado.

Program Goals

The goals of the Medicaid Mental Health Capitation and Managed Care Program continue to evolve as the State learns from experience. The goals of the Program are:

1. *to promote and assist in the recovery of individuals with mental illnesses through innovative services that empower consumers and families to determine and achieve their goals;*

2. *to assure access to necessary mental health services for consumers and families;*

3. *to provide the appropriate mix of mental health services that meet the needs of each individual consumer and family;*

4. *to assure that quality services are provided to consumers and families;*

5. *to provide all necessary services through a cost-effective system;*

6. *to achieve a coordinated system of delivering mental health services to Medicaid and non-Medicaid Colorado citizens; and*

7. *to continue to manage the cost of the mental health system and to control the rate of future cost increases.*

II. General Description of the Waiver Program

~~**Previous Waiver Period**~~

~~**a.** ___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:~~

Upcoming Waiver Period -- For items a. through m. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. **The State of *Colorado*** requests a waiver under the authority of section 1915(b)(1) of the Act. The waiver program will be operated ~~directly~~ by the Medicaid agency.

b. **Effective Dates:** This waiver renewal is requested for a period of 2 years; effective *April 10, 2003* and ending _____

c. **The waiver program is called *the Medicaid Mental Health Capitation and Managed Care Program.***

d. **State Contact:** The State contact person for this waiver is *Bill Bush, Director, Mental Health Capitation Program who can be reached by telephone at (303) 866-7411, or fax at (303) 866-7428, or e-mailed at bill.bush@state.co.us*.

e. **Type of Delivery Systems:** The State will be entering into the following types of contracts with the ~~MCO or~~ PIHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PIHP program for mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully). Please note this answer should be consistent with your response in Section A.II.d.1 and Section D.I.

~~1. ___ **Risk-Comprehensive (fully-capitated- MCOs, HIOs, or certain PIHPs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:~~

~~(a)___ The contractor is at-risk for inpatient hospital services and any one of the following services:~~

~~i.___ Outpatient hospital services,~~
~~ii.___ Rural health clinic (RHC) services,~~
~~iii.___ Federally qualified health clinic (FQHC) services,~~
~~iv.___ Other laboratory and X-ray services,~~
~~v.___ Skilled nursing facility (NF) services,~~
~~vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,~~
~~vii.___ Family planning services,~~
~~viii.___ Physician services, and~~
~~ix.___ Home Health services.~~

~~(b)___ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.II.d.1.~~

2. ✔ **Other Risk (partially-capitated or PIHP):** Other risk contracts having a scope of risk that is less than comprehensive are referred to as partially-capitated. PIHPs are the contractors in these programs (e.g., a PIHP for mental health/substance abuse). References in this preprint to PIHPs generally apply to these other risk entities. Please check either (a) or (b); if (b) is chosen, please check the services which apply. In addition to checking the appropriate item, please provide a brief narrative of the other risk (PIHP) model, which will be implemented by the State:
~~(a)___ The contractor is at-risk for inpatient hospital services,~~
OR

(b) ✔ The contractor is at-risk for ~~two or fewer of~~ the *following* ~~below~~ services ~~((i) through (ix)).~~

i. ✔ *All* outpatient *mental health* ~~hospital~~ services,
~~ii.___Rural health clinic (RHC) services,~~
iii. ✔ Federally qualified health clinic (FQHC) *mental health* services,
~~iv.___Other laboratory and X-ray services,~~
~~v.___Skilled nursing facility (NF) services,~~

~~vi.___Early periodic screening, diagnosis and treatment (EPSDT) services,~~
~~vii.__Family planning services,~~
~~viii.__Physician services, and~~
~~ix.___Home Health services.~~

x.✔ *A range of other mental health services including emergency services, inpatient and residential services.*

The following describes the risk model required by the RFP2000:

"The contractor shall be at full risk for the cost of providing all necessary covered services to all enrolled individuals. The contractor shall provide all necessary services even if the cost exceeds the payments made by the State to the contractor under this contract." [2]

~~3.___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., an MCO contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.~~

~~4.___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):~~

f. **Statutory Authority:** The State's waiver program is authorized under **Section 1915(b)(1) of the Act**, which provides for a capitated managed care program under which the State restricts the entity from or through which an enrollee can obtain medical care.

g. **Other Statutory Authority.** The State is also relying upon authority provided in the following section(s) of the Act:

[2] *RFP2000 Section III-17. Attachment A.II.e.2.*

1. ~~**1915(b)(2) -** A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.III.B Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.~~

2. ✔ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

   Please list additional services to be provided under the waiver which are not covered under the State plan in Section A.III.d.1 and Appendix D.III. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to HCFA approval.

   The RFP2000 states:

   "…The following services are not included in the State Medicaid Plan, but are required under the Medicaid Mental Health Capitation and Managed Care Program's contracts and must be available on the first day of the contract term:

   - *residential*
   - *school-Based Services*
   - *vocational*
   - *home-Based Services for Children and Adolescents*
   - *intensive Case Management"* [3]

   "One of the primary reasons for implementing the Colorado Medicaid Mental Health Capitation and Managed Care Program was to broaden the scope of services that are available to Medicaid eligible individuals, so that consumers may receive services that are designed to meet individual needs. Under the Program, the contractor has the flexibility to provide whatever services are medically/clinically necessary to effectively treat each consumer's illness.

[3] *RFP2000 Section III-36. Attachment A.II.e.2.*

The contractor is expected to develop and provide new services not previously reimbursed by the Medicaid fee-for-service program and not included in the required services described above. Examples of new service options are:

- *respite care;*
- *consumer drop-in centers;*
- *clubhouses;*
- *peer counseling and support services;*
- *peer mentoring for children and adolescents;*
- *assertive community treatment programs;*
- *warm lines;*
- *specialized services for addressing adoption issues;*
- *early intervention services;*
- *family support, education and training services;*
- *multi-systemic therapy;*
- *supported living services;*
- *prevention services*
- *recovery groups;*
- *supportive employment; and*
- *peer-run employment services*

Offerors may propose to provide these and any other services that are appropriate in the treatment of individuals with a mental illness."[4]

The proposals from the PIHPs contain a variety of optional services such as those listed above.

3. ✔ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

[4] *RFP2000 Section III-37. Attachment A.II.e.2.*

h. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1. ~~**Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.~~

2. ✔ **Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as ~~case management~~ *respite care* and *residential services* ~~health education~~ that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3. ✔ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through a ~~MCO or~~ PIHP.

4. ~~**Section 1902(a)(30)** - Upper Payment Limits--This Section of the Act require that payments to a contractor may not exceed the cost to the agency of providing those same services on a FFS basis to an actuarially equivalent nonenrolled population. Under this waiver, a contractor may receive a capitation rate and any other applicable payment which may cause total payments to the contractor to exceed the upper payment limits for the capitated services in a given waiver year. The waiver must still be cost-effective for the two-year period. An example of a program with this waiver is a partial capitation program, where the State gives the capitated entity (or entities) a bonus (which in conjunction with the capitation payment exceeds the UPL) for reductions in Medicaid expenditures for high cost areas, but the State demonstrates cost-effectiveness on the basis that total waiver program expenditures are less than total without waiver program expenditures.~~

~~5.___ **Other Statutes Waived -** Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their HCFA Regional Office to identify required submission items from this format.~~

i. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1. ✔ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

~~2. Other (please list in the table below):~~

Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity (~~MCO~~, PIHP, ~~HIO, or other entity~~) with which the State will contract:

Counties	Current Contractor	Type of Entity	Start Date	CMHC Area
Adams Arapahoe & Douglas	Behavioral HealthCare, Inc.	PIHP	August 1, 1995	Adams-MHC Arapahoe/Douglas-MHC Aurora-MHC
Clear Creek, Gilpin & Jefferson	Jefferson Center for Mental Health	PIHP	August 1, 1995	Jefferson-MHC
Boulder & Broomfield[5]**	Mental Health Center of Boulder County	PIHP	August 1, 1995	Boulder-MHC
Weld Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Yuma & Larimer	Northeast Behavioral Health	PIHP	August 1, 1995 May 1, 1998	North Range Behavioral Health Centennial-MHC Larimer-MHC
Baca, Bent, Crowley, Kiowa, Otero, Prowers Huerfano, Las Animas, Pueblo, Chaffee, Custer, Fremont, Lake, Alamosa, Conejos, Costilla, Mineral, Rio Grande & Saguache	SyCare/Options Colorado Health Networks	PIHP	September 1, 1995	Southeastern-MHC Spanish Peaks-MHC West Central-MHC San Luis Valley-MHC
Eagle, Garfield, Grand, Jackson, Mesa, Moffat, Pitkin, Rio Blanco, Routt, Summit, Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel, Archuleta, Dolores, La Plata, Montezuma & San Juan	West Slope/Options Colorado Health Networks	PIHP	September 1, 1995	Colorado West-MHC Midwestern-MHC Southwestern-MHC
El Paso, Park & Teller	Access Behavioral Care-Pikes Peak[6]**	PIHP	October 1, 2001	Pikes Peak-MHC
Denver	Access Behavioral Care-Denver	PIHP	June 1, 1998	Mental Health Corp of Denver

Boulder, Weld, and Adams counties.

September 1, 1995.

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

j. MCO Requirement for Choice: Section 1932(a)(3) of the Act requires States to permit individuals to choose from not less than two managed care entities.

~~1.___ This model has a choice of managed care entities.~~
~~(a)__ At least one MCO and PCCM~~
~~(b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM preprint instead of this capitated preprint)~~
~~(c)__ Two or more MCOs~~
~~(d)__ At least one PIHP and a combination of the above entities~~

~~2.___ This model is an HIO.~~

3.✔ Other: the State requests a waiver of 1932(a)(3). Please list the reasons for the request (Please note: The exception to choice in rural areas, under Section 1932(a)(3) will not apply until final promulgation of the Balanced Budget Act Medicaid Managed Care regulations):

The State requires a choice of providers within the contractor's network. The RFP2000 enhanced provider choice through the following provisions of the contract:

"The contractor shall have a network of providers that includes a sufficient number of providers who possess the appropriate training and expertise to meet the varying mental health needs of the enrolled population.

The provider network shall be extensive enough to allow the vast majority of consumers and families to have a choice of providers, including a choice between Community Mental Health Center providers and other private practitioners, provider organizations and facilities (e.g. psychiatrists, psychologists, social workers, clinics, hospitals, etc.). Even if the Community Mental Health Center(s) in the geographic service area can meet the mental health needs of the population without other, private providers, the contractor still must include in its network as many private providers as necessary to offer consumers and families choices of providers. The State

understands that in some geographic areas, particularly in rural areas, there are a limited number of private providers of mental health services, and will take this into consideration when evaluating provider networks. The contractor must demonstrate to the State that it has an adequate provider network given the availability of providers in its region." [7]

And

"The contractor shall offer a contract or a single case agreement to every provider who is serving at least one enrollee at the time of contract implementation, as long as the provider meets the contractor's criteria for credentialing and quality of care. The purpose of this requirement is to protect consumers from having to change providers at the time the contract is implemented." [8]

And

"After contract implementation, the contractor shall offer a contract or a single case agreement to any provider requested specifically by a consumer or family, as long as the provider meets the contractor's credentialing and quality of care criteria. The purpose of this requirement is to offer the greatest degree of choice for consumers and families." [9]

And

"The contractor shall offer a contract to every other MHASA whose employees provide direct clinical services and to every Community Mental Health Center in the State. The contractor (if its employees provide direct clinical services) shall accept the offers of other MHASAs to be in those other MHASAs' networks, and shall accept referrals from other MHASAs. The purposes of this requirement are:

- *to allow consumers and families to receive services at the MHASA or CMHC of their choice;*
- *to accommodate children and adolescent consumers who are placed away from their home communities; and*

[7] *RFP2000 Section III-28-A. Attachment A.II.e.2.*
[8] *RFP2000 Section III-28-B. Attachment A.II.e.2.*
[9] *RFP2000 Section III-28-C. Attachment A.II.e.2.*

- *to facilitate services when a consumer experiences a need for services while away from home."* [10]

And

"…Consumers, parents and others with legal custody shall be free to choose any provider who has met the contractor's credentialing requirements and is included in the contractor's network as long as the following criteria are met:

- *the consumer has a medical/clinical need for the service;*
- *the provider is qualified to provide the needed service; and*
- *the provider is willing to accept the consumer into her/his care.*

As long as these criteria are met, the contractor shall allow the consumer, parent or person with legal custody to see the provider of her/his choice. The contractor shall not include any additional criteria or place any additional restrictions on a consumer, parent or person with legal custody's right to choose a provider." [11]

And

"…The contractor shall honor and accommodate consumers' preferences whenever possible. For consumers who do not request a specific provider, the contractor also shall offer a choice of providers meeting the consumer's preferences whenever possible. The contractor shall document in the clinical record each consumer's preferences and requests for providers, noting whether the consumer's preferences were honored, and the reasons for not honoring preferences…" [12]

And

"…Upon request, the contractor shall allow a consumer to access services from any other MHASA or CMHC with which the contractor has a contract to provide services. The contractor shall work

[10] *RFP2000 Section III-28-D. Attachment A.II.e.2.*
[11] *RFP2000 Section III-79-A. Attachment A.II.e.2.*
[12] *RFP2000 Section III-79-C. Attachment A.II.e.2.*

directly with the other MHASA or CMHC to make all necessary arrangements, including service authorizations, billing, and payment. The contractor shall not place the burden on the consumer or family to make the necessary arrangements…" [13]

And

"…Upon request of a consumer, parent or person with legal custody, the contractor shall accept a consumer from any other MHASA or CMHC with which the contractor has a contract to provide services. The contractor shall work directly with the other MHASA or CMHC to make all necessary arrangements, including service authorizations, billing, and payment. The contractor shall not place the burden on the consumer or family to make the necessary arrangements…" [14]

And

"…The contractor shall not require a consumer who needs multiple services (e.g. a therapist and a psychiatrist) to receive those services from the same organization (e.g. a CMHC) or at the same location. For example, the contractor may not require a consumer to receive therapy from a CMHC clinician as a condition of seeing the CMHC psychiatrist.

If a consumer chooses two or more providers who are employed by different organizations and/or located in different places, the consumer's assigned Care Coordinator shall take appropriate measures to coordinate care to the consumer.

If a consumer chooses two or more providers who are employed by different organizations, such as a CMHC psychiatrist and a therapist in private practice, it may be necessary for the contractor to have a written affiliation agreement between the providers that addresses issues such as control of treatment, liability, coordination, and monitoring. The contractor shall work to implement such written agreements, as necessary.

The contractor may require a consumer to receive services from providers who are employed by the same organization and/or located in the same place only if there is a compelling, overriding clinical reason for doing so. Convenience of the contractor or provider, and ease of care coordination do not qualify as compelling, overriding clinical reasons for implementing this provision of the

[13] *RFP2000 Section III-79-D. Attachment A.II.e.2.*
[14] *RFP2000 Section III-79-E. Attachment A.II.e.2.*

contract. Any case where the contractor requires a consumer to receive different services from the same organization and/or at the same location shall be documented and justified in the consumer's clinical record." [15]

k. Waiver Population Included: The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1. ✔ Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2. ✔ Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3. ✔ Blind/Disabled Children and Related Populations (SSI)

4. ✔ Blind/Disabled Adults and Related Populations (SSI)

5. ✔ Aged and Related Populations (Please specify: SSI, QMB, Medicare, etc.)

6. ✔ Foster Care Children

~~7. ___ Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid~~

~~8. ___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.~~

~~9. ___ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)~~

~~i. ___ Children with special needs due to physical and/ or mental illnesses,~~

[15] *RFP2000 Section III-79-F. Attachment A.II.e.2.*

ii.___ Older adults,
iii.___ Foster care children,
iv.___ Homeless individuals,
v.___ Individuals with serious and persistent mental illness and/or substance abuse,
vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii.__ Other (please list):

I. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1.___ have Medicare coverage, except for purposes of Medicaid-only services;

2.___ have medical insurance other than Medicaid;

3.___ are residing in a nursing facility;

4.___ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5.___ are enrolled in another Medicaid managed care program;

6.___ have an eligibility period that is less than 3 months;

7.___ are in a poverty level eligibility category for pregnant women;

8.___ are American Indian or Alaskan Native;

9.___ participate in a home and community-based waiver;

10.__ receive services through the State's Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12.__ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);
i.___ Children with special needs due to physical and/ or mental illnesses,
ii.___ Older adults,
iii.___ Foster care children,

~~iv.___ Homeless individuals,~~
~~v.___ Individuals with serious and persistent mental illness and/or substance abuse,~~
~~vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or~~
~~vii.__ Other (please list):~~

~~13.__ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:~~

m. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

~~**n. Independent Assessment:** The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to HCFA at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and HCFA's "Independent Assessment: Guidance to States" for more information].~~ Please check one of the following:

~~1.__ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to HCFA as required.~~

2.✔ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments ~~unless HCFA finds reasons to request additional evaluations as a result of this renewal request. In these instances, HCFA will notify the State that an Independent Assessment is needed in the waiver approval letter.~~

III. Program Impact

In the following informational sections, please complete the required information to describe your program. The questions should be answered ~~for MCOs and, if applicable,~~ for PIHPs.

a. **Marketing** including indirect ~~MCO~~/PIHP marketing (e.g., radio and TV advertising for the ~~MCO~~/PIHP in general) and direct ~~MCO~~/PIHP marketing (e.g., direct mail to Medicaid beneficiaries). For information to enrollees (i.e., member handbooks), see Section H.

Previous Waiver Period

~~1.___ During the last waiver period, the program marketing policies operated differently than described in the waiver governing that period. The differences were:~~

~~2.___ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements [items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint], as well as results of the monitoring.~~

The State did not permit direct or indirect PIHP marketing during the last waiver period.

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.✔ The State does not permit direct or indirect ~~MCO~~/PIHP marketing (go to item "b. Enrollment/Disenrollment")

~~2.___ The State permits indirect MCO/PIHP marketing (e.g., radio and TV advertising for the MCO/PIHP in general). Please list types of indirect marketing permitted.~~

~~3.___ The State permits direct MCO/PIHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.~~

~~Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.~~

4.___ The State prohibits or limits MCOs/PIHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:

5.___ The State permits MCO/PIHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6.___ The State requires MCO/PIHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the MCO/PIHP service area.

ii.__ The languages comprise all languages in the MCO/PIHP service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

7.___ The State requires MCO/PIHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **MCO Required Marketing Elements**: Listed below is a description of requirements which the State must meet under the waiver program (items 1.a through 1.g). These items are optional PIHP marketing elements. If an item is not checked, please explain why. The State:

(a)__ Ensures that all marketing materials are prior approved by the State

(b)__ Ensures that MCO marketing materials do not contain false or misleading information

(c)__ Consults with the Medical Care Advisory Committee (or subcommittee) in the review of MCO marketing materials

(d)__ Ensures that the MCO distributes marketing materials to its entire service area

~~(e)__ Ensures that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment.~~

~~(f)___ Ensures that the MCO does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing.~~

~~(g)__ Ensures that MCO does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.~~

b. Enrollment/Disenrollment:

Previous Waiver Period

~~1.___ During the last waiver period, the enrollment and disenrollment operated differently than described in the waiver governing that period. The differences were:~~

2. ✔ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements (items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint). Please include the results from those monitoring efforts for the previous waiver period.

Recipients are automatically enrolled in the program and the State's staff monitor the automated enrollment process. Since the beginning of the program in 1995, the State has granted exemptions per the State's Medicaid Capitation regulations regarding exemption from the Program.[16] Currently, twenty-one (21) consumers from five (5) geographic service areas are exempt from the program. Consumers granted an exemption are manually enrolled in the Medicaid fee-for-service program by the State's staff.

Not Guilty by Reason of Insanity (NGRI)

Prior to July 01, 2001, the not guilty by reason of insanity (NGRI) population (15 – 20 individuals) institutionalized in the State's mental health hospital was included in the Medicaid Mental Health Capitation Program. Treatment was court ordered and subsequently directed by the hospital. The State recognized that treatment for this

[16] *10 CCR 2505 10 §8.212. Attachment A.III.b.*

population could not be effectively managed by the PIHPs and made the decision to exempt this population from the Medicaid Mental Health Program and return the NGRI population to coverage under fee for service. The rates paid to the PIHPs were adjusted to reflect the exemption of this population.

Regional Center Residents

In the State's three Regional Centers, most mental health services are provided on-site to the developmentally disabled residents by Regional Center staff. Prior to July 1, 2001, the PIHPs were responsible for providing a limited array of mental health services to Medicaid eligible residents that were not provided in the Regional Centers, such as emergency and inpatient hospital services. An audit of the State's Developmental Disability programs called into question the issue of splitting mental health treatment between two sources. Since the PIHPs were unable to effectively manage mental health services to these clients, they were exempted from the Medicaid Mental Health Program and returned to coverage under fee for service as of July 1, 2001. The rates paid to the PIHPs were adjusted to reflect this exemption.

Upcoming Waiver Period - Please describe the State's enrollment process for ~~MCOs~~/PIHPs by checking the applicable items below. For items 1. through 6. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

~~1.___ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out-stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:~~

2.✔ **Administration of Enrollment Process**:

(a)✔ State staff conduct the enrollment process.

~~(b)__ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and~~

~~related activities. The State must request a waiver of 1915(b)(2) in Section A.II.g.1. (Refer to Section 2105 of the State Medicaid Manual)~~

~~i. Broker name: _____~~

~~ii. Procurement method:~~

~~(A). ____Competitive~~

~~(B). ____Sole source~~

~~iii. Please list the functions that the contractor will perform:~~

~~(c)__ State allows MCOs/PIHPs to enroll beneficiaries. Please describe the process and the State's monitoring.~~

3. **Enrollment Requirement:** Enrollment in the program is:

(a)✔Mandatory for populations in Section A.II.k.

*In the upcoming waiver period, the State will exempt the Incompetent to Proceed (ITP) and other forensics population institutionalized in the State's mental health hospital from the Program. Treatment for this population is court ordered and subsequently directed by the hospital. The State recognizes it cannot be effectively managed by the PIHPs and will return the ITP/other forensics population to coverage under fee for service. The rates paid to the PIHPs will be adjusted to reflect the exemption of this population.***

~~(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):~~

~~(c)___ Other (please describe):~~

4. **Enrollment:**

~~(a)__ The State will make counseling regarding their MCO/PIHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff,~~

~~the counseling process, and information provided to potential enrollees.~~

~~(b)__ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PIHPs and providers based on their medical needs. Please describe.~~

~~(c)__ Enrollees will notify the State/enrollment broker of their choice of plan by:~~
~~i.____ mail~~
~~ii.____ phone~~
~~iii.____ in person at ____~~
~~iv.____ other (please describe):~~

~~(d)__ [Required for MCOs and PIHPs] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).~~

~~(e)__ Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.~~

(f)__✔__ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

"All persons who are eligible for Medicaid in the contract area, and who are entitled to a full range of mental health benefits, will automatically be enrolled by the State in the contractor's Program." [17]

Medicaid eligible individuals are enrolled in the Mental Health Capitation and Managed Care Program on a retrospective basis. All new Medicaid recipients are enrolled in the Program as of the first day of the month in which their eligibility was determined and entered into the Medicaid eligibility information system. The State transitioned to the

[17] *RFP2000 Section III-6. Attachment A.II.e.2.*

*current retrospective enrollment system from the prospective system in early 2000.***

~~(g)__ If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned to a plan.~~

i. ~~Potential enrollees will have____days/month(s) to choose a plan.~~

ii. ~~Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PIHP that includes their current provider or to an MCO/PIHP that is capable of serving their particular needs?~~

~~(h)__ The State provides guaranteed eligibility of____ months for all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?~~

(i)__✔__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an ~~MCO~~/PIHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

The following State Medicaid Rules (8.212.01 & 8.212.02) describe the circumstances under which an enrollee is eligible for an exemption from enrollment:

"ENROLLMENT OF RECIPIENTS

All persons who are eligible to receive Medicaid mental health benefits shall be enrolled in the Program, unless exempted as provided below.

EXEMPTIONS

A recipient may request to be exempt from the Program. Mental Health Services shall consider the request if: a) the recipient has a clinical relationship with a provider of mental health services that the recipient wishes to maintain, and that provider is not part of the MHASA's provider network; or b) the recipient and the MHASA have been unable to develop a healthy working relationship, and continued enrollment in the Program would not be in the best clinical interest of the

recipient. The process for requesting and granting exemptions is as follows:

If the recipient has a clinical relationship with a provider of mental health services that he/she wishes to maintain:

A. The recipient shall notify the MHASA of the recipient's desire to receive his/her necessary mental health services from the provider with whom the recipient has established a clinical relationship.

B. No later than fourteen (14) calendar days after receiving notice from the recipient, the MHASA shall determine whether it can make appropriate arrangements with the recipient's chosen provider to provide necessary mental health services to the recipient. The MHASA shall provide written notice to the recipient and the recipient's chosen provider of this determination. If the MHASA is unable to meet the recipient's request, the MHASA shall identify one or more service providers within the MHASA's provider network who can appropriately meet the recipient's mental health care needs.

The MHASA's written notice to the recipient also shall include information on the recipient's right to request an exemption from the Program, the process for requesting an exemption, and information on assistance that is available to the recipient.

C. After receiving written notice from the MHASA that the MHASA is unable to make appropriate arrangement with the recipient's chosen provider, the recipient may file a request for an exemption with Mental Health Services. Upon request of the recipient, the MHASA shall assist the recipient to file a request for an exemption.

D. No later than thirty (30) calendar days after receiving the recipient's request for exemption, Mental Health Services shall determine whether to exempt the recipient from the Program, and provide written notice of its determination to the recipient, the recipient's provider, and the MHASA. Mental Health Services shall determine whether to exempt the recipient from the Program based upon a determination of what is in the best clinical interest of the recipient.

E. The recipient has the right to appeal the determination of MHS to an Administrative Law judge (ALJ), pursuant to the rules in Section 8.058 of this Staff Manual.

F. A newly eligible Medicaid recipient who is requesting an exemption from the Program will be enrolled in the Program pending the outcome of the request for exemption, and appeal to the Department.

A Medicaid recipient who is enrolled in the Program and is requesting an exemption from the Program, will continue to be enrolled in the Program pending the outcome of the request for exemption and appeal to the Department.

If, in the view of the recipient, the recipient and the MHASA have been unable to develop a healthy working relationship, and continued enrollment in the Program would not be in the best clinical interest of the recipient:

A. The recipient shall notify Mental Health Services of the recipient's desire to be exempt from the Program.

B. No later than thirty (30) calendar days after receiving the recipient's request for exemption, MHS shall determine whether to exempt the recipient from the Program, and provide written notice of its determination to the recipient and the MHASA. MHS shall determine whether to exempt the recipient from the Program based

upon a determination of what is in the best clinical interest of the recipient.

C. The recipient has the right to appeal the determination of MHS to an Administrative Law Judge, pursuant to the rules in Section 8.058 of this Staff Manual.

D. A Medicaid recipient who is enrolled in the Program and is requesting an exemption from the Program, will continue to be enrolled in the Program pending the outcome of the request for exemption and appeal to the ALJ.

If after receiving an exemption from the Program, a recipient wishes to end the exemption and re-enroll in the Program, the recipient shall notify Mental Health Services of the recipient's desire to re-enroll in the Program. Within thirty (30) calendar days after receiving the recipient's request, Mental Health Services shall: 1) approve the request and notify the recipient of the date he/she will be re-enrolled in the Program; 2) work with Department of Health Care Policy and Financing staff to re-enroll the recipient in the Program; and 3) notify the MHASA of the recipient's request and the re-enrollment, prior to the effective date of re-enrollment." [18] **

5. **Disenrollment:**

~~(a)__ The State allows enrollees to disenroll/transfer between MCOs/PIHPs. Please explain the procedures for disenrollment/transfer:~~

~~(b)__ The State does not allow enrollees to disenroll from the PIHP.~~

~~(c)__ The State monitors and tracks disenrollments and transfers between MCOs/PIHPs. Please describe the tracking and analysis:~~

[18] *10 CCR 2505 10 §8.212. Attachment A.III.b.*

(d)__ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i.___ MCO enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO.

ii.___ PIHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PIHP

ii.___ MCO enrollees must be notified of their ability to disenroll or change MCOs at the end of their enrollment period at least 60 days before the end of that period.

iii.___ MCO and PIHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:

(e)__ The State does not have a lock-in, and enrollees in MCOs/PIHPs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

6. **MCO/PIHP Disenrollment of Enrollees**: If the State permits MCOs/PIHPs to request disenrollment of enrollees, please check items below which apply:

(a)__ The MCO/PIHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, **it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee**. Please describe the reasons for which the MCO/PIHP can request reassignment of an enrollee:

(b)__ The State reviews and approves all MCO/PIHP-initiated requests for enrollee transfers or disenrollments.

(c)__ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP to remove the enrollee from its membership.

~~(d)___ The enrollee remains a member of the MCO/PIHP until another MCO/PIHP is chosen or assigned.~~

c. Entity Type or Specific Waiver Requirements

Previous Waiver Period

~~1.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:~~

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period. For items 1. through 4. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.✔ **Required ~~MCO~~/PIHP Elements:** ~~MCOs~~/PIHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a) The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i.✔ Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

ii. ✔ ~~MCO~~/PIHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii. ✔ ~~MCO~~/PIHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv. ✔ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v. ✔ There are no restrictions that discriminate among classes of providers on ground unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has~~/will~~ select*ed* the ~~MCOs~~/PIHPs that will operate under the waiver in the following manner:

(a) ✔ The State has used/~~will use~~ a competitive procurement process. Please describe.

The RPF2000 was competitively bid according to the State of Colorado Procurement Code and Rules. The relevant procurement rules are outlined below:

"(R-24-102-202.5-02)

Use of BIDS - Goods and Services

(a) After the State Purchasing Director determines that BIDS can meet the state's requirements for notification and competitive solicitation for the procurement of goods and services, BIDS shall be the only notification method used for competitive solicitations for goods and services made through Invitations for Bids (IFB), Requests for Proposals (RFP), and Documented Quotes (DQ), except as provided in paragraphs (i) through (iii) below.

(i) If a purchasing agency or office solicits bids, proposals or quotes using BIDS and receives no responsive bids, proposals, or quotes, or if the responsible purchasing official otherwise reasonably determines in writing that BIDS will not yield adequate competition, the agency or office may use such additional notification methods as it deems appropriate to seek competition.
(ii) If the agency requires delivery in less than 12 business hours, documented quotes may be sought by other means, as set forth in paragraph (iii) below, in conjunction with, or instead of, BIDS.
(iii) When the responsible purchasing official has determined that BIDS will not yield adequate competition, pursuant to paragraph (i) or (ii) above, documented quotes may be sought by telephone, direct contact, fax, or mail.
(b) Bids, proposals, and quotes shall not be deemed responsive unless the responding vendor is registered for BIDS, except in those situations set forth in paragraphs (i) through (iii) above.
When a purchase is awarded in response to an IFB, , DQ, or any other notification placed on BIDS, the responsible purchasing official shall promptly put the appropriate award data on BIDS.

(R-24-103-101-01)

Terms Defined in This Chapter.

As used in this chapter, unless the context otherwise requires:

(f) "Request for Proposals (RFP)" is the commonly used name for competitive sealed proposals. Formal RFPs shall be used in all cases where the total expected cost of the procurement is in excess of $25,000 and the provisions of §24-101-203 apply. Procurements for which the resulting contract is expected to be for more than one fiscal period must take into account the costs for the full life of any resulting contract to determine total expected cost.

(R-24-103-203-05)

Dollar Thresholds for, and Content of, Requests for Proposals (RFP's).

(a) Formal RFPs. Formal RFP's shall be issued (promulgated) by the Division of Purchasing, or agencies with delegated purchasing authority, for requirements that are estimated to exceed

$25,000, utilizing guidelines for formal RFPs established by the Division of Purchasing
(b) Form of Proposal. The manner and format in which proposals are to be submitted, including any forms for that purpose, shall be as set forth in the Request for Proposals.

(R-24-103-203-06)

Vendor Inquiries

In cases where an RFP raises questions or concerns from vendors, or may require interpretation, all known participating vendors must be given an opportunity to ask questions and to receive answers or clarifications. This may be accomplished by use of a pre-proposal conference, via a formal inquiry period, or a combination of options. If any of these options is anticipated, the RFP shall so state and shall list appropriate dates, times and locations.

Pre-proposal conferences may be mandatory or optional. However, if such meetings result in any material changes to the scope of work or otherwise affect the manner or form of response, all known potential offerors must be notified in writing of any such change.

Similarly, if responses to inquiries result in any material changes to the scope of work or otherwise affect the manner or form of response, all known potential offerors must be notified in writing of any such change.

When such written notice is given, offerors must be afforded a reasonable amount of time to review these materials, to contemplate any consequences and to consider the content for inclusion in their offers.

(R-24-103-203-07)

Proposal Preparation Time.

Proposal preparation time for formal RFPs shall be set to provide offerors a minimum of 30 calendar days to prepare and submit their proposals. However, when special requirements or conditions exist, the State Purchasing Director or head of a purchasing agency may shorten this time, but in no case shall the time be shortened in order to reduce competition. The State Purchasing Director or head of a

purchasing agency shall document why the reduced time period was necessary.

(R-24-103-203-08)

Opening and Recording of Proposals.

Proposals shall be opened publicly and a register of proposals shall be prepared which shall include the name of each offeror.

(R-24-103-203-09)

Evaluation of Proposals.

Evaluation Factors in the Request for Proposals. The Request for Proposals shall state all of the evaluation factors, including price. The evaluation shall be based on the evaluation factors set forth in the Request for Proposals. Numerical rating systems may be used. Factors not specified in the Request for Proposals shall not be considered.
(a) Veterans' Preference. The relative weight assigned to a criterion, as to the extent and quality of any preference for veterans of military service given by offeror in the hiring of offeror's employees, shall not exceed 5%.
(b) Minority Business Enterprises.
(i) When a competitive sealed proposal process is conducted for commodities or services, and past discrimination against minority businesses can be shown, the RFP shall contain an evaluation criterion, in addition to price and other appropriate criteria, evaluating the extent of MBE participation offered in the proposal. Disparity or predicate studies accepted by other public entities may be used as evidence establishing past discrimination in the geographical area of the study for the goods or services involved.
(ii) The goal established in each procurement for MBE participation, against which the extent of participation shall be measured, and the weight assigned to the criterion which considers the extent of offeror's MBE participation, shall be determined on a case-by-case basis, but in no event shall the weight assigned to such criterion exceed the lesser of a goal established as a result of the disparity study relied upon as evidence of past discrimination, or the 17% goal established by the Governor's Executive Order D005587.
(iii) In establishing the goal, and the weight of the criterion which considers such goal, consideration shall be given to:
A. the extent to which subcontracting, or the use of suppliers, is permitted by the RFP or is possible in the response to the RFP; and

B. the extent to which Minority Business enterprises exist in the particular marketplace and industry to provide the specific goods or services sought by the State in the RFP; and
C. the extent to which the procuring agency is exceeding, on an annual aggregate basis, the goals of the Executive Order at the time the RFP is prepared.
(c) Women's Business Enterprises.
(i) When a competitive sealed proposal process is conducted for commodities or services, and past discrimination against women's businesses can be shown, the RFP shall contain an evaluation criterion, in addition to price and other appropriate criteria, evaluating the extent of WBE participation offered in the proposal. Disparity or predicate studies accepted by other public entities may be used as evidence establishing past discrimination in the geographical area of the study for the goods or services involved.
(ii) The goal for WBE participation established in each procurement against which the extent of participation shall be measured, and the weight assigned to the criterion that considers the extent of offeror's WBE participation, shall be determined on a case by case basis, but in no event shall such criterion exceed the goal established as a result of the disparity findings relied upon as directed by the Governor's Executive Order D0005-94.
(iii) In establishing the goal, and the weight of the criterion that considers such goal, consideration shall be given to:
A. the extent to which subcontracting, or the use of suppliers, is permitted by the RFP or is possible in the response to the RFP; and
B. the extent to which Women's Business Enterprises exist in the particular marketplace and industry to provide the specific goods or services sought by the State in the RFP; and
C. the extent to which actual WBE participation in the agency's contracts, resulting from RFPs, issued during the current year have exceeded the goals set in those same RFPs, on an aggregate basis.
(d) Tie bids. In all solicitations for personal services, by competitive sealed proposal, any tie between offerors shall be broken by awarding the contract to the offeror utilizing the greatest quantitative (numerical) preference for veterans in hiring offeror's employees.
(e) Classifying Proposals. for the purpose of conducting discussion with offerors, proposals shall be initially classified as:
(i) acceptable;
(ii) potentially acceptable, that is, reasonable susceptible of being made acceptable; or
(iii) unacceptable.

(R-24-103-203-10)

Proposal Discussion with Individual Offerors after Opening.

Purpose of Discussion. Discussions may be held to:
(a) promote understanding of the State's requirements and the offeror's proposals; and
(b) facilitate arriving at a contract that will be most advantageous to the State taking into consideration price and the other evaluation factors set forth in the Request for Proposals.
(c) Conduct and Purpose of Discussion. Offerors shall be accorded fair and equal treatment in discussion and revision of their proposals. After RFP's have been opened, discussions may be held with those offerors determined to be most responsive. Discussions may be held to clarify requirements and to make adjustments in services to be performed and in costs and/or prices. Auction techniques and/or disclosure of any information derived from competing proposals are prohibited. Any changes to the proposal, technical or costs, shall be submitted/confirmed in writing by the contractor(s).

(R-24-103-203-11)

Award.

Awards shall be made to the responsible offeror whose proposal is determined to be most advantageous to the State based on the evaluation factors set forth in the Request for Proposals. The evaluation committee established to evaluate offers shall make such determination subject to final approval by the Director or head of a purchasing agency.

(R-24-103-206-05)

Competitive Negotiation.

(a) When a competitive solicitation (IFB or RFP) is unsuccessful, the State Purchasing Director, or head of a purchasing agency, may initiate a competitive negotiation among vendors capable of fulfilling the State's need. Vendors who responded to the initial solicitation, and any rebid, should be contacted.
(b) The competitive negotiation process may also be used in those cases where, in the determination of the State Purchasing Director or head of a purchasing agency, there are not enough

vendors to satisfy the requirement for adequate competition as defined herein.

(c) After negotiations have been conducted, the responsible procurement official has the authority to make a selection that represents the best offer to the State. In all such cases a written determination shall be made that identifies the nature of the discussion that occurred with each vendor and shall include a description of why the awarded offer was most advantageous to the State. Proprietary information that may have been provided during the negotiations will be handled in accordance with Rule R-24-103-202a-08c, and should be separately retained and properly identified.

(d) Each vendor with whom competitive negotiation occurs shall be afforded a fair and equal chance to compete for the State's need. Negotiations shall be conducted with each offeror separately and independently. In no case shall any vendor's offer be communicated to any other vendor until after an intent to award has been announced.

(e) This source selection method may only be used when at least one of the above conditions has been met. When it is otherwise likely that adequate competition does exist, this option shall not be used.

(f) After an unsuccessful competitive solicitation. A competitive sealed solicitation (IFB or RFP) is unsuccessful when offers received pursuant to the solicitation are unreasonable, noncompetitive, or the low bid exceeds available funds as certified by the appropriate fiscal officer, and time or other circumstances will not permit the delay required to re-solicit. If emergency conditions exist after an unsuccessful competitive solicitation, an emergency procurement may be made." [19]

~~(b) The State has used/will use an open cooperative procurement process in which any qualifying MCO/PIHP may participate that complies with federal procurement requirements and 45 CFR Section 74.~~

[19] *State of Colorado Procurement Code and Rules, January 1, 1999.*

~~(c)___ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.~~

~~4.___ Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts and the default enrollment process now established for MCOs.~~

d. SERVICES

Previous Waiver Period

~~1. .___During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:~~

2. ✔ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. [items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

The Medicaid Mental Health Capitation Team has monitored the following areas for compliance with the PIHPs' contractual requirements:

- *Clinical Programs and Services*
- *Provider Credentialing/Subcontracting*
- *Reporting Suspected Fraud*
- *Claims Processing and Payment*
- *Access to Services*
- *Mechanism for the Provision of Mental Health Services/Referrals to the Colorado Works Population*
- *Mental Health/Differential Diagnosis Determination*
- *Member Handbooks*
- *Provider Handbooks*

- *Quality Improvement Program Descriptions and Workplans*
- *Needs Assessment Program Evaluations*

The Program Quality Team has also performed site reviews. These reviews included medical chart audits, policy reviews, and staff interviews. The results of these monitoring efforts have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period. For items 1. through 7. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

~~1. The Medicaid services MCO/PIHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are/are not in the MCO/PIHP contract; which non-covered services are impacted by the MCO/PIHP (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the MCO/PIHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:~~

~~**(Column 1 Explanation) Services**: The list of services below is provided as *an example only. States should modify the list to include:*~~
- ~~all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver~~
- ~~subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services~~
- ~~services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)~~

~~**(Column 2 Explanation) State Plan Approved**: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.~~

~~**(Column 3 Explanation) 1915(b)(3) waiver services**: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.~~

~~**(Column 4 Explanation) MCO/PIHP Capitated Reimbursement**: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PIHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.~~

~~**(Column 5 Explanation) Fee-for-Service Reimbursement:** Check this column if this service will NOT be the responsibility of the MCO/PIHP, i.e. not included in the reimbursement paid to the MCO/PIHP. However, do not include services impacted by the MCO/PIHP (see column 6).~~

~~**(Column 6 Explanation) Fee-for-Service Reimbursement impacted by MCO/PIHP**: Check this column if the service is not the responsibility of the MCO/PIHP, but is impacted by it. For example, if the MCO/PIHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PIHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PIHP (see column 5).~~

Service	State Plan Approved	1915(b)(3) waiver services	PIHP Capitated Reimburse-ment	Fee-for-Service Reimburse-ment	Fee-for-Service Reimburse-ment impacted by PIHP
65 and over Psychiatric (A)	X		X		
Case Management (B)	X		X		
Emergency (C)	X		X		
Home-based Services for children and adolescents (D)		X	X		
Inpatient Hospital (E)	X		X		
Intensive Case Management (F)		X	X		
Medication Management (G)	X		X		
Outpatient (H)	X		X		

Service	State Plan Approved	1915(b)(3) waiver services	PIHP Capitated Reimburse-ment	Fee-for-Service Reimburse-ment	Fee-for-Service Reimburse-ment impacted by PIHP
Outpatient-Laboratory Services	X			X	X
Pharmacy	X[20]			X	X
Physician (I)	X		X		
Psychosocial Rehabilitation (J)	X		X		
Rehabilitation (K)	X		X		
Residential (L)		X	X		
School-based Services (M)		X	X		
Transportation-Emergency	X[21]			X	X
Transportation-other than emergency	X[20]			X	X
Under 21 Psychiatric (N)	X		X		
Vocational (O)		X	X		

Required services are defined as follows: [22]

"A. 65 and Over Psychiatric -- A program of care for consumers age 65 and over in which the consumer remains 24 hours a day in an institution for mental diseases, or other facility licensed as a hospital by the State.

[20] *(RFP2000 Section III-49) Prescription Drugs - Prescription drugs currently are excluded from the Mental Health Capitation and Managed Care Program, but remain a benefit of the Colorado Medicaid Program for consumers enrolled in the mental health program.*

[21] *(RFP2000 Section III-54) Transportation Services - Currently, contractors are not responsible for the cost of transportation services included in the State Medicaid Plan for consumers who need transportation to access mental health services. Contractors, however, are responsible for assisting consumers to access their Medicaid transportation benefits, and for making all necessary mental health services accessible to consumers, including providing transportation services not included in the State Medicaid Plan, as necessary. The State may include the cost of Medicaid Transportation services for consumers who need transportation to access mental health services, in the Mental Health Capitation and Managed Care Program in the future.*

[22] *RFP2000 Section III-36. Attachment A.II.e.2.*

B. Case Management -- Activities that are community-based and are delivered in the consumer's environment, including:

- *service planning;*
- *outreach;*
- *referral;*
- *supportive interventions;*
- *crisis management;*
- *linkage;*
- *service coordination and continuity of care;*
- *monitoring/follow-up; and*
- *advocacy.*

C. Emergency -- Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to an urgent or crisis situation with a consumer.

D. Home-Based Services for Children and Adolescents -- Therapeutic services for children/adolescents and their families provided in their homes.

E. Inpatient Hospital -- A program of psychiatric care in which the consumer remains 24 hours a day in a facility licensed as a hospital by the State.

F. Intensive Case Management -- Community-based services averaging more than one hour per week, provided to children with serious emotional disturbances and adults with serious mental illness who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services may include, but are not limited to mentoring.

G. Medication Management -- Monitoring of medications prescribed and consultation provided to consumers by a physician.

H. Outpatient -- A program of care in which the consumer receives services in a hospital or other health care facility, but does not remain in the facility 24 hours a day.

I. Physician -- Services provided within the scope of practice of medicine as defined by State law.

J. Psychosocial Rehabilitation -- A broad array of services to maximize consumers' ability to live and participate in the community and to function independently. Service options include but are not limited to:

- *assessment of interests and abilities;*
- *development of individualized goals and timelines;*
- *assistance in understanding and coping with one's illness;*
- *crisis planning;*
- *recognition of and skill development to offset the realities of stigma and feelings of lack of control over one's life;*
- *daily living skills;*
- *education;*
- *recreation/leisure time use;*
- *social interactions; and*
- *providing information and assisting in accessing peer oriented groups, including but not limited to social, support, counseling and advocacy groups.*

K. Rehabilitation -- Services provided under the Rehabilitation Option of the Medicaid Program, including:

- *Partial Long Day -- Therapeutic contact with a consumer lasting more than four hours but less than 24 hours. Activities are programmatically linked.*
- *Partial Short Day -- Therapeutic contact with a consumer lasting more than two hours, but no more than four hours. Activities are programmatically linked.*
- *Group -- Therapeutic contact with more than one consumer, of up to and including two hours.*
- *Individual -- Therapeutic contact with one consumer of more than 30 minutes, but no more than two hours.*
- *Individual Brief -- Therapeutic contact with one consumer of up to and including 30 minutes.*

L. Residential -- Any type of 24 hour care provided in a non-hospital, non-nursing home setting, where the contractor provides room, room and board, or room, board and supervision. Residential services are appropriate for children, youth, adults and older adults who need 24 hour supervised care in a therapeutic environment.

M. School-Based Services -- Mental health services provided to school aged children and adolescents on site in their schools, with the cooperation of the schools.

N. Under 21 Psychiatric -- A program of care for consumers under age 21 in which the consumer remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the State.

O. Vocational -- Services designed to help adult and adolescent consumers to gain employment skills and employment."

2. **Emergency Services (Required)**. The State must ensure enrollees in ~~MCOs~~/PIHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. For PIHPs, "emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.
~~For MCOs, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.~~

(a) ✔ The State has a more stringent definition of emergency medical condition for ~~MCOs or~~ PIHPs than the definition above. Please describe.

"Emergency medical condition"

"the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy." [23]

[23] *DOI Regulation 4-2-17 Section 4.H. Prompt Investigation of Health Plan Claims Involving Utilization Review. Attachment A.III.d.2.*

And:

In addressing the review of claims for emergency services, Colorado Insurance Regulations state that:

"A health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent layperson having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed. Under these same circumstances, a claim for emergency services necessary to screen and stabilize a covered person shall not be denied for failure by the covered person or the emergency service provider to secure prior authorization. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall not deny a claim for emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state or local law requires the use of a specific provider." [24]

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b)✔ The State ensures enrollee access to emergency services by requiring the ~~MCO~~/PIHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)✔ The State ensures enrollee access to emergency services by including in the contract requirements for ~~MCOs~~/PIHPs to

[24] *DOI Regulation 4-2-17 Section 6.G. Attachment A.III.d.2.*

cover the following. ~~Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PIHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.~~

~~i.___ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,~~

ii.✔ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii.✔ Both the screening/evaluation and stabilization services when a clinical emergency is determined,

iv.✔ Continued emergency services until the enrollee can be safely discharged or transferred,

~~v.___ Post-stabilization services which are pre-authorized by the MCO/PIHP, or were not pre-authorized, but the MCO/PIHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PIHP contacts the emergency room and takes responsibility for the enrollee.~~

~~3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PIHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.~~

~~(a)__ Enrollees are informed that family planning services will not be restricted under the waiver.~~

(b)___ Non-network family planning services are reimbursed in the following manner:

i.___ The MCO/PIHP will be required to reimburse non-network family planning services

ii.___ The MCO/PIHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii.___The State will pay for all family planning services, whether provided by network or non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) __ Family planning services are not included under the waiver.

4.___ **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PIHPs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):

5.___ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PIHP to track, coordinate, and monitor services to which an enrollee can self-refer:

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished by the MCO/PIHP to the enrollee during the enrollment period.

(b)✔ The program is **mandatory** ~~and the enrollee is guaranteed a choice of at least one MCO/PIHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PIHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available.~~

Please explain how the State will guarantee all enrollees will have a choice of at least one ~~MCO~~/PIHP with a participating FQHC:

The RFP2000 requires the contractor to offer sub-contracts to FQHCs providing mental health services within their service area:

"Federal Medicaid regulations and this RFP require that the contractor offer to subcontract with Federally Qualified Health Centers (FQHCs) located in the contract service area that provide the mental health services included in this RFP. The contractor is not required to contract with every FQHC that provides mental health services in its geographic area. Rather, the contractor is required to offer contracts to a sufficient number of FQHCs so that enrollees who wish to receive mental health services through an FQHC have an opportunity to do so. In an area with a number of FQHCs that provide mental health services, a contractor may only need to contract with several of those FQHCs to meet this requirement. In an area with only one or a few FQHCs that provide mental health services, a contractor may need to offer contracts to all of those FQHCs to meet this requirement." [25]

~~(c)__ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.~~

[25] *RFP2000 Section III-28-F. Attachment A.II.e.2.*

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

~~(a) __ The State requires MCOs/PIHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.~~

~~(b) __ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: HCFA requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the HCFA 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.~~

~~(c) __ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?~~

~~(d) __ Managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.~~

~~(e) __ Mechanisms are in place to coordinate school services with those provided by the MCO/PIHP. Please describe and clarify the aspects of school services that are coordinated including IEPS, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan~~

~~requirements for PCP cooperation or involvement in the development of the IEPs).~~

(f) ✔ Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the ~~MCO/~~PIHP. Please describe.

The RFP2000 requires the contractor to coordinate their assessment process with the PCP to obtain the results of any EPSDT screen:

"The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal program requiring States to assure that physicians and other health care providers conduct comprehensive health screenings of children and adolescents up to age 21. Under federal Medicaid regulations, any service necessary to treat health care needs identified through an EPSDT screening must be provided through the Medicaid Program even if the identified service is not included in the State's Medicaid Plan.

An EPSDT screening covers a wide range of health care services including: physical exam, assessment of developmental and emotional status, hearing, vision, and dental screen. EPSDT screenings are conducted by primary care physicians, county health department nurses, and other health care providers who refer consumers to a variety of specialists, as necessary. The contractor shall coordinate with the EPSDT program by:

- *offering to educate physicians, county health department nurses, and other health care providers on the requirement to refer children and adolescents who need mental health services to the contractor or a provider in the contractor's network, and the referral process;*
- *accepting referrals of children and adolescents screened through the EPSDT program;*
- *assessing the needs of children and adolescents referred for services;*
- *providing needed mental health services; and*
- *coordinating services with the child's primary care physician or other provider, as appropriate.*

As part of the assessment of all children and adolescents, the provider shall attempt to determine from the consumer or her/his parent, guardian, or primary care physician, whether the consumer has been screened under the federal EPSDT program. If the consumer has been screened under the EPSDT program, the provider shall attempt to contact the consumer's primary care physician or other provider to obtain any results of the screening that indicate a need for mental health services. The provider shall consider the results of EPSDT screenings in assessing the need for mental health services." [26]

[26] *RFP2000 Section III-3. Attachment A.II.e.2.*

IV. Attachments

Memorandum of Understanding (FY 2001) between Health Care policy and Financing (HCPF) and Mental Health Services (MHS). Attachment A.I.

Colorado Medicaid Mental Health Capitation and Managed Care Program – Request for Proposals – April, 2000 (RFP2000). Attachment A.II.e.2.

10 CCR 2505 10 §8.212 "Mental Health Capitation Program." Attachment A.III.b.

DOI Regulation 4-2-17. Attachment A.III.d.2.

Section B. Access and Capacity

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency ~~and family planning~~ services must not be restricted.

I. Access Standards

Previous Waiver Period

a. ✔ During the last waiver period, the access standards of the program were operated differently than described in the waiver governing that period. The differences were:

Effective September 13, 2002, emergency and routine access to services standards for the PIHPs were changed. The change was approved by the State as a cost saving measure. The total dollar value of the PIHPs' contracts was reduced by 3.72 percent in FY '03.

While not explicitly stated, compliance with the standards that were presented in the prior waiver renewal was defined as 100 percent. This created inefficiencies in the PIHPs staffing patterns, particularly in regard to the provision of emergency services, since the PIHPs were required to maintain excess staff to cover the relatively rare incidence of the demand for service exceeding capacity.

The table below compares the standards that went into effect in September, 2002, with the previous standards.

	Old Standard	*New Standard (effective 9/13/2002)*
Emergency Services	• Available by phone within 15 minutes • In-person contact within 1 hour urban, 2 hours rural	No change • In-person contact within 1 hour urban – 90% of the time. • In-person contact within 2 hour urban –

	Old Standard	New Standard (effective 9/13/2002)
		100% of the time. • In-person contact within 2 hours rural – 90% of the time. • In-person contact within 4 hours rural – 100% of the time.
Urgent Services	Available within 24 hours	No change
Routine Services	Available within 7 calendar days	• Available within 7 calendar days – 90% of the time. • Available within 14 calendar days – 100% of the time.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the State's availability standards for the upcoming waiver period.

a. **Availability Standards**: The State has established *standards* ~~maximum distance and/or travel time requirements, given clients normal means of transportation,~~ for ~~MCO/~~PIHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10, 11 and 12.

~~1.___ PCPs (please describe your standard):~~

~~2.___ Specialists (please describe your standard):~~

~~3.___ Ancillary providers (please describe your standard):~~

~~4.___ Pharmacies (please describe your standard):~~

~~5.___ Hospitals (please describe your standard):~~

6. ✔ Mental Health (please describe your standard):

*The access standards for emergency, urgent, and routine services are listed above in Section B, I., a (Previous Waiver Period).***

Please note that an "emergency" condition is defined earlier in this Statement of Work. An "urgent" condition is defined as "a situation that has the potential to become an emergency in the absence of treatment." [27]

~~7. Substance Abuse Treatment Providers (please describe your standard):~~

~~8. Dental (please describe your standard):~~

~~9. Other providers (please describe your standard):~~

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the standards described above.

The RFP2000 establishes how the State will monitor access to emergent care:

"…The contractor shall document the response time (from initial contact to beginning of the face-to-face evaluation) for all emergency services requiring a face-to-face evaluation." [28]

Urgent and routine care are monitored for compliance by a medical chart audit:

"… the State shall have the right to access all contractor information, including confidential clinical information, pertaining to consumers served under the contract. Upon request, the contractor shall provide clinical records and/or other information, or otherwise make requested materials available for State inspection, without a written release from the consumer.

Colorado Mental Health Services will monitor the provision of services by reviewing a sample of clinical records. The State also

[27] *RFP2000 Section III-73. Attachment A.II.e.2.*
[28] *RFP2000 Section III-38-B. Attachment A.II.e.2.*

may interview consumers, family members, clinicians or other knowledgeable persons, or obtain and review information through other methods to determine whether appropriate services have been provided." [29]

Sanctions and enforcement of the contract (i.e. failure to meet access standards) will follow the conditions outlined in the RFP2000:

"The contractor shall comply with the final determination of the Clinical Review Board and the instructions of the State within twenty-four (24) hours of notification if the State determines an emergency to exist, and within seven (7) calendar days in non-emergency cases, or face the following financial sanction:

> *$200 for each day of non-compliance for each case of non-compliance, back to the date the State directed the contractor to take specific action and continuing until corrective action is implemented;*
>
> *OR*
>
> *one and one-half times the cost of providing the appropriate services (as determined by the State), back to the date the State directed the contractor to take specific action and continuing until corrective action is implemented, whichever is higher.*

A contractor that, in the judgment of the State, has repeated cases where appropriate services have not been provided that indicates an ongoing or systemic problem, will be subject to the following actions in addition to any financial sanctions that may be assessed:

- *development by the contractor of a corrective action plan, subject to approval by the State, and implementation of the plan; and/or*
- *increased monitoring by the State.*

These actions may be initiated by the State regardless whether the contractor corrects identified cases of non-compliance before financial sanctions are assessed.

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[29] *RFP2000 Section III-90. Attachment A.II.e.2.*

If a contractor is required by the State to develop a corrective action plan, the contractor shall have fifteen (15) calendar days to develop the plan. If the contractor's plan requires revisions, as determined by the State, the contractor shall have fifteen (15) calendar days from the date the plan is returned by the State to make the revisions and re-submit the plan to the State. If the contractor is unable or unwilling to develop a plan within fifteen (15) calendar days or to satisfactorily revise a plan within fifteen (15) calendar days, the contractor will be subject to the following sanctions:

- *$500 for each day, beginning on the first day after the fifteen-day time period has expired, and continuing until the day a plan is submitted; and/or*
- *corrective action plan developed by the State, for implementation by the contractor.*

If a contractor is unwilling or unable to implement a corrective action plan to the satisfaction of the State by the date(s) included in the State-approved plan, the contractor will be subject to the following sanctions:

- *$500 for each day, beginning on the first day after the implementation date included in the corrective action plan, and continuing until the day the contractor successfully demonstrates to the State that it has implemented the plan; and*
- *other remedies included in Appendix B (Remedies) of this RFP.*

Any financial sanctions assessed by the State will be deducted from the monthly payment to the contractor.[30]

11. Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver.

Under the waiver renewal, services will continue to be provided in a variety of settings not available in the Fee-for-Service System. All

[30] *RFP2000 Section III-92-D. Attachment A.II.e.2.*

Community Mental Health Centers (CMHCs) in the State are participating providers in the Medicaid Mental Health Capitation and Managed Care Program. These Centers and their satellite offices cover all service areas of the State. In addition, each PIHP will contract with a variety of private practitioners, hospitals, clinics and private agencies throughout their service area. The RFP2000 requires that the contractor service consumers in a variety of community settings:

"The State believes that, to the greatest extent possible, services should be provided in the community rather than in institutional settings. Community settings provide opportunities for consumers to be and feel integrated into their communities, and help to reduce the feelings of stigma and isolation that consumers often experience. While some services must be provided in hospitals and other institutional settings, the contractor should provide other services in non-institutional settings whenever possible. In addition, the contractor should provide outpatient services in settings that are convenient and comfortable for consumers and families, such as in schools, homes, recreational centers, and other community settings where consumers are located." [31]

12. Please explain how the ~~MCOs~~/PIHPs will be required to enable enrollees to access providers.

The RPF2000 requires contractors to assure that enrollees have access to providers:

"…the State must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance of the residences of Program enrollees. Colorado statutes also require that services be provided in a manner that accommodates or is compatible with the enrollee's ability to fulfill duties and responsibilities in work and community activities (26-4-115(2)(e)(II), C.R.S.). The contractor must demonstrate that its services are accessible. This shall include:

- *employing and/or subcontracting with a sufficient number of service providers throughout the geographic service area to ensure that consumers have timely access to services;*

[31] *RFP2000 Section III-57. Attachment A.II.e.2.*

- *providing services in locations that are reasonably accessible to consumers, such as services within a reasonable distance of consumers' homes, and services accessible by public transportation;*

- *providing services at times that meet consumers' needs, including some evening and weekend hours;*

- *providing or arranging for transportation for consumers to service sites, as appropriate;*

- *bringing services to locations that are convenient to consumers, such as homes, schools, community centers, and public buildings, as appropriate; and*

- *conducting outreach efforts to identify and offer assistance to enrollees who are in significant need of mental health services but are not receiving services.*

The State recognizes that certain geographic locations, such as rural areas, face unique problems due to the distances between people and between communities, the relatively small numbers of people who may need specific types of services, the lack of a sufficient number of mental health professionals, and difficulties in recruiting professionals to the area." [32]

Each PIHP must submit to the State an annual Provider Network Adequacy plan and an annual evaluation based on their plan's parameters. The evaluation must demonstrate that appropriate services are both accessible and available. The State will certify to CMS, using the data and analyses that the PIHPs submit, that the provider networks are adequate.

b. Appointment Scheduling (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for ~~MCO~~/PIHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

[32] *RFP2000 Section III-73. Attachment A.II.e.2.*

~~1.___ PCPs (please describe your standard):~~

~~2.___ Specialists (please describe your standard):~~

~~3.___ Ancillary providers (please describe your standard):~~

~~4.___ Pharmacies (please describe your standard):~~

~~5.___ Hospitals (please describe your standard):~~

6.✔ Mental Health (please describe your standard):

*The standards for access to services are presented in Section B, I., a.***

~~7.___ Substance Abuse Treatment Providers (please describe your standard):~~

~~8.___ Dental (please describe your standard):~~

~~9.___ Other providers (please describe your standard):~~

10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above.

The State monitors compliance for emergency, urgent, and routine services on an ongoing basis. The Medicaid Mental Health Program Capitation Team performed a review of the PIHPs' routine, urgent, and emergency access data during the previous waiver period and has continued to monitor access on an ongoing basis. Results of the Capitation Team's monitoring have also been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services.

For enforcement see Section B.I.a.10 above.

11. Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling.

The state monitors compliance based on the standards established for emergent, urgent and routine services. There is no data available on "non-waiver" appointment scheduling.

c. In-Office Waiting Times: The State has *not* established standards for in-office waiting times for ~~MCO~~/PIHP enrollee's access to the following. ~~Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.~~

~~1.___ PCPs (please describe your standard):~~

~~2.___ Specialists (please describe your standard):~~

~~3.___ Ancillary providers (please describe your standard):~~

~~4.___ Pharmacies (please describe your standard):~~

~~5.___ Hospitals (please describe your standard):~~

~~6.___ Mental Health (please describe your standard):~~

~~7.___ Substance Abuse Treatment Providers (please describe your standard):~~

~~8.___ Dental (please describe your standard):~~

~~9.___ Other providers (please describe your standard):~~

~~10. Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the in-office waiting time standards checked above.~~

~~11. Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times.~~

II. Access and Availability Monitoring

Enrollee access to care will be monitored as part of each ~~MCO~~/PIHP's Internal Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA).

Previous Waiver Period

~~**a.**___ During the last waiver period, the access and availability monitoring was operated differently than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring ~~*MCO*~~/PIHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint].

During the last waiver period the Medicaid Mental Health Capitation Team and the Program Quality Team as reported in Section III.A.c.2 and section III.A.d.3 of this document monitored access to and availability of care.

Upcoming Waiver Period -- For items a. through o. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check below any of the following (a-o) that the State will also utilize to monitor access:

a. ✔ Measurement of access to services during and after a ~~*MCO*~~/PIHP's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., ~~PCPs'~~ *PIHPs'* 24-hour accessibility will be monitored through random calls to *PIHPs* during regular and after office hours)

b. ✔ Determination of enrollee knowledge on the use of managed care programs

c. ✔ Ensures that services are provided in a culturally competent manner to all enrollees.

d. ✔ Review of access to emergency ~~or family planning~~ services without prior authorization

e. ✔ Review of denials of referral requests

~~**f.**___ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.~~

g. ✔ Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

~~**h.** ___ Measurement of enrollee requests for disenrollment from a MCO/PIHP due to access issues~~

i. ✔ Tracking of complaints/grievances concerning access issues

~~**j.** ___ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)~~

~~**k.** ___ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.~~

l. During monitoring, the State will look for the following indications of access problems.

1. ✔ Long waiting periods to obtain services ~~from a PCP~~.
~~2. ___ Denial of referral requests when enrollees believe referrals to specialists are medically necessary.~~
3. ✔ Confusion about how to obtain services not covered under the waiver.
4. ✔ Lack of access to services after ~~PCP's~~ regular office hours.
~~5. ___ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.~~
6. ✔ Lack of access to emergency ~~or family planning~~ services.
~~7. ___ Frequent recipient requests to change a specific PCP.~~
~~8. ___ Other indications (please describe):~~

m. ✔ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n. ✔ Monitoring the provider network showing that there will be providers within ~~the~~ *reasonable* distance/travel times ~~standards~~.

~~**o.** ___ Other (please explain):~~

III. Capacity Standards

Previous Waiver Period

~~**a.**___ During the last waiver period, the capacity standards were operated differently than described in the waiver governing that period. The differences were:~~

b. ✔ [Required] ~~MCO~~/PIHP Capacity Standards. ~~The State ensured that the number of providers under the waiver remained approximately the same or increased compared to the number before the implementation of the waiver.~~ Please describe the results of this monitoring.

The State does not use the "number of providers" as a measure of capacity, instead, adequate capacity is determined by monitoring access to services and consumer satisfaction. The program's access standards are described in detail in Section B.I.a. In addition, the PIHPs are required to submit to the State annual Provider Network Adequacy Plans and Evaluations. Network capacity is a key dimension of the provider network's adequacy. The PIHPs' FY '02 Network Adequacy Plans and Network Adequacy Evaluations have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).

~~c.___ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate and that provider capacity remained approximately the same or improved under the waiver. Please describe the results of this monitoring.~~

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the capacity standards for the upcoming two year period.

a. ~~MCO~~/PIHP Capacity Standards

~~1.___ The State has set enrollment limits for the MCO/PIHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.~~

~~2.___ The State monitors to ensure that there are adequate open panels within the MCO/PIHP. Please describe how often and how the monitoring takes place.~~

3.✔ [Required] The State ensures that the *provider capacity* ~~number of providers~~ under the waiver is expected to remain approximately the same or increase compared to ~~the number~~ before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver.

"The number of providers" is not an adequate measure of capacity in the Program. Prior to implementation, many "participating" mental health providers in Colorado were not taking new Medicaid cases. Under fee-for-service many of the current network providers were not participating providers.

The State "ensures" capacity through contractual language that requires the contractor to maintain an adequate network:

"Offerors must demonstrate that they have the corporate resources and commitment necessary to successfully implement and operate the Medicaid Mental Health Capitation and Managed Care Program in the service areas included in their proposals. Specifically, offerors must demonstrate they have:

…a sufficient number of employees with the skills and experience necessary to perform the work of the contract…

…the ability to develop a regional network of providers possessing the clinical skills and experience needed to meet the needs of the population enrolled in the Program…

…the capacity to adequately serve the number of Medicaid recipients and the demographic mix of recipients in the service area in a timely manner…".[33]

In addition, the PIHPs are required to submit to the State annual Provider Network Adequacy Plans and Evaluations. Network capacity is a key dimension of the network's adequacy.

[33] *RFP2000 Section III-3. Attachment A.II.e.2.*

4. [Required] ~~For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before the waiver, during the current waiver period and the number projected for the proposed renewal period.~~ **Please provide a definition of your geographic area,** i.e. by county, region or capitated rate area. ~~Please complete only for the providers included in your waiver program.~~

The Program divides the State of Colorado into eight Geographic Service Areas incorporating one or more counties. The only change since the previous waiver period is the addition of Broomfield County to the Boulder MHASA. Broomfield County was established November 15, 2001, from parts of Jefferson, Boulder, Weld, and Adams counties.

Geographic Service Area	Counties
Northern Colorado	Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Yuma, Weld & Larimer
Southern Colorado	Baca, Bent, Crowley, Kiowa, Otero, Prowers, Huerfano, Las Animas, Pueblo, Chaffee, Custer, Fremont, Lake, Alamosa, Conejos, Costilla, Mineral, Rio Grande & Saguache
Western Colorado	Eagle, Garfield, Grand, Jackson, Mesa, Moffat, Pitkin, Rio Blanco, Routt, Summit, Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel, Archuleta, Dolores, La Plata, Montezuma & San Juan
Colorado Springs	El Paso, Park & Teller
Denver	Denver
East Metro Denver	Douglas, Adams & Arapahoe
West Metro Denver	Clear Creek, Gilpin & Jefferson
Boulder	Boulder & Broomfield

~~For risk-comprehensive programs, please modify to reflect your State's program and complete the following chart:~~

~~For risk-comprehensive programs, please modify to reflect your State's program and complete the following chart:~~

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
FQHCs			
Hospitals			
Pharmacies			
Primary Care Providers (Please specify) - Family Practice - Internal Medicine - OB/GYNs - Pediatricians - Physician Extenders			
Other (please specify)			

*Please note any limitations to the data in the chart above here:
For other risk programs, please modify for your State's program and complete the following chart:

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Developmental Disabilities Providers (please specify)			
Hospitals			
Mental Health Providers (please specify)			
Pharmacies			
Substance Abuse Treatment & Rehab Providers (please specify)			
Transportation Providers (please specify)			
Vision Providers			
Other (please specify)			

*Please note any limitations to the data in the chart above here:

b. ~~PCP Capacity Standards~~

~~1. The State has set capacity standards for PCPs within the MCOs/PIHP expressed in the following terms (In the case of a PIHP, a PCP may be defined as a case manager or gatekeeper):~~

~~i. PCP to enrollee ratio~~
~~ii. Maximum PCP capacity~~
~~iii. For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans?~~

~~2. The State ensures adequate geographic distribution of PCPs within MCO/PIHPs. Please explain.~~

~~3. The State designates the type of providers that can serve as PCPs. Please list these provider types.~~

c. Specialist Capacity Standards

1. ✔ The State has set capacity standards for specialty services. Please explain.

All providers in the program are mental health specialists. Access standards are listed in Section B.I.a.

2. ✔ The State monitors access to specialty services. Please explain how often and how monitoring is done.

The State has recently begun to monitor access to emergency, urgent, and routine access to services on a quarterly basis and will continue to do so. In addition, network adequacy plans and evaluations are required of the PIHPs annually. A key component of these evaluations is an assessment of access to services. The State reviews and approves the network adequacy plans and evaluations.

~~3. The State requires particular specialist types to be included in the MCO/PIHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If specialist types are not involved in the MCO/PIHP network, please describe how arrangements are made~~

~~for enrollees to access these services (for waiver covered services only).~~

~~Specialist Provider Type~~	~~Adult~~	~~Pediatric~~	~~Standards~~
~~Addictionologist and/or Certified Addiction Counselors~~			
~~Allergist/Immunologist~~			
~~Cardiologist~~			
~~Chiropractors~~			
~~Dentist~~			
~~Dermatologist~~			
~~Emergency Medicine specialist~~			
~~Endocrinologist~~			
~~Gastroenterologist~~			
~~Hematologist~~			
~~Infectious/Parasitic Disease Specialist~~			
~~Neurologist~~			
~~Obstetrician/Gynecologist~~			
~~Oncologist~~			
~~Ophthalmologist~~			
~~Orthopedic Specialist~~			
~~Otolaryngologist~~			
~~Pediatrician~~			
~~Psychiatrist~~			
~~Pulmonologist~~			
~~Radiologist~~			
~~Surgeon (General)~~			
~~Surgeon (Specialty)~~			
~~Other mental health providers (please specify)~~			
~~Other dental providers(please specify)~~			

~~Specialist Provider Type~~	~~Adult~~	~~Pediatric~~	~~Standards~~
~~Other (please specify)~~			

IV. Capacity Monitoring

Previous Waiver Period

a. ~~During the last waiver period, the capacity monitoring was operated differently than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the ~~MCO~~/PIHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint].

During the previous waiver period, the Medicaid Mental Health Capitation Team reviewed the PIHPs' data on routine, urgent, and emergency access to services. Several issues were identified as a result of this review. The first was inadequate data gathering systems in three PIHPs along with inadequate internal monitoring of access. Second, six PIHPs had experienced, at some point during the waiver period, problems with meeting routine access standards. Corrective actions were implemented by the PIHPs and the State continues to monitor access on an ongoing basis. The detailed results of this monitoring have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services.

In addition, the State used a complaint reporting system that requires the contractors to report complaints regarding a variety of issues including access to care. The State's complaint database for the period covering this waiver includes a summary of complaints by category, including accessing services, treatment options and choice. Complaints regarding access have been investigated and documented. The annual "Complaints Summary" for FY '01 and '02 have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services.

Upcoming Waiver Period -- For items a. through l. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.
Please indicate which of the following activities the State employs:

~~**a.**___ Periodic comparison of the number and types of Medicaid providers before and after the waiver.~~

~~**b.**___ Measurement of referral rates to specialists.~~

~~**c.**___ Provider-to-enrollee ratios~~

d.✔ Periodic ~~MCO~~/PIHP reports on provider network

~~**e.**___ Measurement of enrollee requests for disenrollment from a plan due to capacity issues~~

f.✔ Tracking of complaints/grievances concerning capacity issues

~~**g.**___ Geographic Mapping (please explain)~~

~~**i.**___ Tracking of termination rates of PCPs~~

~~**j.**___ Review of reasons for PCP termination~~

k.✔ Consumer Experience Survey, including persons with special needs,

~~**l.**___ Other (Please explain):~~

V. Continuity and Coordination of Care Standards

Previous Waiver Period

~~**a.**___ During the last waiver period, the continuity and coordination of care standards were operated differently than described in the waiver governing that period. The differences were:~~

Upcoming Waiver Period -- For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check any of the following that the State requires of the ~~MCO~~/PIHP:

~~**a.**___ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs~~

b. ✔ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.

c. ✔ Health education/promotion. Please explain.

The RFP2000 requires that the contractor provide public education:

"The contractor shall provide public education to ensure that consumers, families, local health and human services agencies and providers, school administrators and teachers, and the general public are knowledgeable about the Mental Health Capitation and Managed Care Program. Public education strategies shall be developed initially and revised as needed with input from consumers, families, and others in the community.

Public education shall address the following:

- *mental illnesses and their symptoms;*
- *the diagnoses that are covered under the Program;*
- *the services that are available through the contractor;*
- *ways to access the service system;*
- *that service decisions are to be made on the basis of need and not on financial considerations;*
- *how to file a complaint with the contractor or the State;*
- *consumer rights, including the right to:*

  - ✓ *be treated with dignity and respect;*
  - ✓ *participate in service planning;*
  - ✓ *receive written information on available services and network providers;*
  - ✓ *choose a provider from the provider network;*
  - ✓ *request that a specific provider be considered for inclusion in the network;*
  - ✓ *receive a second opinion;*
  - ✓ *confidentiality;*
  - ✓ *refuse treatment, except as provided by law;*
  - ✓ *receive copies of clinical records and service plans;*
  - ✓ *have an independent advocate;*
  - ✓ *file a complaint;*
  - ✓ *available and accessible covered services when medically necessary, including availability of appropriate care 24 hours a day, 7 days a week for urgent and emergent conditions;*

- ✓ *receive culturally appropriate and competent services from participating providers;*
- ✓ *interpreter services for consumers with communication disabilities or for non-English speaking consumers when such an interpreter is necessary in order to render effective communication in connection with the provision of covered services;*
- ✓ *receive from the consumer's provider, in terms that the consumer understands, an explanation of her/his complete condition, recommended treatment, risks of the treatment, expected results and reasonable alternatives. If the consumer is not capable of understanding the information, the explanation shall be provided to the consumer's biological, adoptive or foster parent, guardian or designated representative, and documented in the consumer's clinical record;*
- ✓ *prompt notification of termination or changes in services or providers;*
- ✓ *express an opinion about the contractor's services to regulatory agencies, legislative bodies, or the media without the contractor causing any adverse effects upon the provision of covered services; and*
- ✓ *any other rights guaranteed by statute or regulation;*

- *consumer and family support and advocacy groups; and*
- *other resources that are available to help consumers and families, including assistance available through the contractor, the State, the independent Ombudsprogram, and other sources.*

Public education shall be tailored to meet the needs of different segments of the public (e.g. consumers and families, community agencies and providers, school personnel, the general public, etc.).

Written materials used for public education should be reviewed by local consumers and family members for readability. The contractor is encouraged to use consumers and family members to provide training, as appropriate." [34]

d. ✔ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the ~~MCO~~/PIHP, taking into account professional standards

[34] *RFP2000 Section III-76. Attachment A.II.e.2.*

e. ✔ There is appropriate and confidential exchange of information among providers.

f. ✔ Informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care

g. ✔ Deals with factors that hinder enrollee compliance with prescribed treatments or regimens.

h. ✔ Case management (please define your case management programs)

The following excerpts from the RFP2000 describe the case management programs/services:

"Case Management -- Activities that are community-based and are delivered in the consumer's environment, including:

- *service planning;*
- *outreach;*
- *referral;*
- *supportive interventions;*
- *crisis management;*
- *linkage;*
- *service coordination and continuity of care;*
- *monitoring/follow-up; and*
- *advocacy."*

And

"…Intensive Case Management -- Community-based services averaging more than one hour per week, provided to children with serious emotional disturbances and adults with serious mental illness who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services may include, but are not limited to mentoring." [35]

[35] *RFP2000 Section III-36. Attachment A.II.e.2.*

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a. ~~During the last waiver period, the continuity and coordination of care monitoring was operated differently than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint].

Continuity and coordination of care has been monitored during the past waiver period by the Program Quality Team through a medical chart audit. The following summarizes the Team's findings related to two monitoring strategies related to continuity and coordination:

Standard: *"Information pertaining to care provided to clients shall be kept in the clinical record."…"A discharge summary for closed records is found which ensures continuity of care and includes a summary of services and progress toward achieving goals, the reason for discharge and instructions or referrals provided."* [36]

FY 01&02 results: *There was documentation of continuity of care in the discharge summary 76.74 percent of the time.* [37] *The standard is 80 percent. In individual site reviews where the documentation of continuity of care fell below 80 percent, corrective actions were required. Corrective actions were reviewed and approved by the State. The State follows up on corrective action plans by monitoring their completion and assessing their effectiveness in subsequent site reviews.*

Standard: *"Information pertaining to care provided to clients shall be kept in a clinical record"… "Services provided by the mental health center, clinic, and/or any outside service providers are integrated into the service plan (e.g., residential, vocational, medication management, case management, wrap around services)."* [38]

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[36] *Program Quality Monitoring Protocol FY02 & FY03. Attachment B.VI.b.*
[37] *Chart Based Outcome Protocol Report FY01 & FY02. Attachment B.VI.b.*
[38] *Program Quality Monitoring Protocol FY02 & FY03. Attachment B.VI.b.*

FY 01&02 results: *The medical chart audit identified that services being provided were integrated 90.51 percent of time.* [39] *This result significantly exceeds the standard of 80 percent. No corrective action plans related to integrated service provision were required.*

c. ✔ [Required for all elements checked in the previous waiver submittal] Please describe any continuity or coordination of care requirements (i.e., information sharing requirements or any efforts that the State has required to avoid duplication of services) with these entities that the State required during the previous waiver period for the entities marked in B.VI in the previous waiver submission. These requirements do not include monitoring efforts.

The RFP2000 outlines the contractor's responsibility to coordinate care:

"The contractor shall be responsible for coordinating the mental health services of each consumer receiving services. The contractor shall assign responsibility for coordinating each consumer's care to a single Care Coordinator. The Care Coordinator may be the consumer's primary therapist, psychiatrist, case manager, or another appropriate person.

The Care Coordinator shall be responsible for service planning, coordination of all mental health services to the consumer, coordination of mental health services with other health and human services, and ensuring that the consumer receives all necessary mental health services. The Care Coordinator shall ensure that different providers who are rendering services to a consumer are aware of the other providers involved in the consumer's treatment and the services being provided by each, as appropriate.

Coordination of care shall address the consumer's need for integration of mental health and other services. This includes identifying, providing, arranging for, and/or coordinating with other agencies to ensure that the consumer receives the health care and supportive services that will allow the consumer to remain in her/his community and to thrive in that community. Recognizing the importance to consumers of needed medical care, the contractor shall make reasonable efforts to assist individuals to obtain necessary medical treatment. If a consumer is unable to arrange for supportive services necessary to obtain medical care due to her/his mental illness, these supportive services shall be provided by the Care

[39] *Chart Based Outcome Protocol Report FY01 and FY02. Attachment B.VI.b.*

Coordinator or another person who has an existing relationship with the consumer whenever possible.

The contractor shall ensure that there is a primary clinical record for each Medicaid consumer who receives mental health services. This record shall include clinical documentation pertaining to the consumer, including documentation of coordination of services to the consumer. The consumer's Care Coordinator, and all providers rendering mental health services to the consumer, shall be identified in the primary clinical record." [40]

d. ✔ [Required for all elements checked in the previous waiver submittal if this is a PIHP mental health, ~~substance abuse, or developmentally disabled population~~ waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PIHP providers are educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems are identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PIHP providers. Please describe how this issue is being addressed in the PIHP program.

In the Medicaid Mental Health Capitation and Managed Care Program, all providers are mental health professionals and PIHPs are required to provide education and coordinate care with other medical providers. Substance abuse is not a covered benefit of the program. Monitoring of coordination of care is described in VI.a. "Upcoming Waiver Period."

The RFP2000 states:

"The contractor shall provide public education to ensure that consumers, families, local health and human services agencies and providers, school administrators and teachers, and the general public are knowledgeable about the Mental Health Capitation and Managed Care Program. Public education strategies shall be developed initially and revised as needed with input from consumers, families, and others in the community.

Public education shall address the following:

- *mental illnesses and their symptoms;*
- *the diagnoses that are covered under the Program;*
- *the services that are available through the contractor;*

[40] *RFP2000 Section III-65. Attachment A.II.e.2.*

- *ways to access the service system;*
- *that service decisions are to be made on the basis of need and not on financial considerations;*
- *how to file a complaint with the contractor or the State;*
- *consumer rights…;*
- *consumer and family support and advocacy groups; and*
- *other resources that are available to help consumers and families, including assistance available through the contractor, the State, the independent Ombudsprogram, and other sources.*

Public education shall be tailored to meet the needs of different segments of the public (e.g. consumers and families, community agencies and providers, school personnel, the general public, etc.)." [41]

The RFP2000 requires contractors to coordinate care with the services of other medical providers:

"The contractor shall coordinate each consumer's mental health services with services of other medical providers, as appropriate. The contractor shall work with the consumer's medical providers to exchange information that is relevant to and necessary for effective treatment of the consumer. This may include providing information to medical professionals that may impact the treatment of medical conditions, such as the use of medications, or the impact of a psychiatric condition on a concurrent medical condition. Coordination also may include obtaining information from medical professionals that may impact the treatment of a psychiatric illness, such as the use of medications, or the existence of a medical condition that may be impacting a psychiatric condition. The State will assist contractors, as necessary, in gaining the cooperation of other health care providers (e.g. Medicaid HMOs, primary care physicians, etc.)

The State urges mental health contractors, HMOs, primary care physicians, and other health care providers to work collaboratively and in the best interests of the individuals, children and families who are served by both the mental health and physical health care systems. The State

[41] *RFP2000 Section III-76. Attachment A.II.e.2.*

also encourages and supports local efforts to coordinate and improve services to individuals, children and families.

The exchange of medical/clinical information shall be conducted in compliance with all applicable laws, rules and regulations concerning the use of and confidentiality of such information." [42]

In addition, the RFP2000 requires contractors to coordinate care with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

"The contractor shall coordinate with the EPSDT program by:

- *offering to educate physicians, county health department nurses, and other health care providers on the requirement to refer children and adolescents who need mental health services to the contractor or a provider in the contractor's network, and the referral process;*
- *accepting referrals of children and adolescents screened through the EPSDT program;*
- *assessing the needs of children and adolescents referred for services;*
- *providing needed mental health services; and*
- *coordinating services with the child's primary care physician or other provider, as appropriate.*

As part of the assessment of all children and adolescents, the provider shall attempt to determine from the consumer or her/his parent, guardian, or primary care physician, whether the consumer has been screened under the federal EPSDT program. If the consumer has been screened under the EPSDT program, the provider shall attempt to contact the consumer's primary care physician or other provider to obtain any results of the screening that indicate a need for mental health services. The provider shall consider the results of EPSDT screenings in assessing the need for mental health services." [43]

[42] *RFP2000 Section III-66. Attachment A.II.e.2.*
[43] *RFP2000 Section III-31. Attachment A.II.e.2.*

e. ✔ [Required if this is a PIHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees are monitored in this waiver program. In addition, please note if pharmacy services are not covered under this program.

Pharmacy services were not a part of the program during the previous waiver period and continued as a benefit in the fee-for-service system. The RFP2000 describes the pharmacy benefit:

"Prescription drugs are excluded from the Mental Health Capitation and Managed Care Program, but remain a benefit of the Colorado Medicaid Program for consumers enrolled in the mental health program. Medicaid consumers who are enrolled in medical HMOs receive prescription drugs through their HMOs. Medicaid consumers who are not enrolled in HMOs receive prescription drugs through pharmacies operating under the Medicaid fee-for-service system.

The contractor's providers shall prescribe medications as appropriate, based on the clinical needs of each consumer. The contractor shall work with HMOs and the Medicaid fee-for-service system to utilize formularies, pharmacies and prior authorization protocols." [44]

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe how standards for continuity and coordination of care will be monitored in the upcoming two-year period.

a. How often and through what means does the State monitor the coordination standards checked above?

Coordination Standard *(From Section V. above)*	***Monitoring Schedule***
b. "…designated clinical practitioner…"	*Annual Program Quality Review/Medical Chart Audit*
c. "…health education/promotion…"	*Periodic Capitation Monitoring*
d. "…health records…"	*Annual Program Quality Review/Medical Chart Audit*
e. "…confidential exchange…"	*Annual Program Quality Review/Medical Chart Audit*

[44] *RFP2000 Section III-49. Attachment A.II.e.2.*

Coordination Standard *(From Section V. above)*	***Monitoring Schedule***
f. "…informs enrollees of specific health conditions…"	*Annual Program Quality Review/Medical Chart Audit*
g. "…compliance with prescribed treatments or regimens…"	*Annual Program Quality Review/Medical Chart Audit*
h. "…case management…"	*Annual Program Quality Review/Medical Chart Audit*

b. Specify below any providers (which are excluded from the capitated waiver) that the State explicitly requires the ~~MCO~~/PIHP to coordinate health care services excluded from the capitated waiver with:

~~1.___ Mental Health Providers (please describe how the State ensures coordination exists):~~

2.✔ Substance Abuse Providers (please describe how the State ensures coordination exists):

The RFP2000 requires the contractor to coordinate mental health services with substance abuse providers:

"The contractor shall be responsible for coordinating with the substance abuse service system for the provision of services to consumers who have dual mental health and substance abuse diagnoses." [45]

And

"The contractor shall work with agencies and providers within the substance abuse service system to coordinate services at the agency level, and to coordinate services to individual consumers. The contractor may choose to develop written agreements with agencies and providers within the substance abuse service system in order to formalize working relationships." [46]

~~3.___ Local Health Departments (please describe how the State ensures coordination exists):~~

~~4.___ Dental Providers (please describe how the State ensures coordination exists):~~

[45] *RFP2000 Section III-70-C. Attachment A.II.e.2.*
[46] *RFP2000 Section III-70-C. Attachment A.II.e.2.*

5. ✔ Transportation Providers (please describe how the State ensures coordination exists):

The RFP2000 requires the contractor to coordinate mental health services with transportation providers:

"Contractors…are responsible for assisting consumers to access their Medicaid transportation benefits, and for making all necessary mental health services accessible to consumers, including providing transportation services not included in the State Medicaid Plan, as necessary." [47]

~~6. ___ HCBS (1915c) Service (please describe how the State ensures coordination exists):~~

7. ✔ Developmental Disabilities (please describe how the State ensures coordination exists):

The RFP2000 requires the contractor to coordinate mental health services with developmental disabilities:

"The contractor shall be responsible for coordinating with the developmental disabilities service system for the provision of services to consumers who have co-occurring mental health and developmental disabilities diagnoses…

The contractor shall enter into a Memorandum of Understanding (MOU) with each Community Centered Board for Developmental Disability Services in the contract service area, to facilitate coordination of services at the agency level and to individual consumers." [48]

~~8. ___ Title V Providers (please describe how the State ensures coordination exists):~~

~~9. ___ Women, Infants and Children (WIC) program~~

[47] *RFP2000 Section III-54. Attachment A.II.e.2.*
[48] *RFP2000 Section III-70-B. Attachment A.II.e.2.*

10.✔ Indian Health Services providers

~~11.__ FQHCs and RHCs not included in the program's networks~~

12.✔ Other (please describe):

The RFP2000 requires the contractor to coordinate mental health services with Child Welfare Services:

"Coordination with the child welfare system has proven to be one of the most critical elements to meeting the needs of children and adolescents and their families. The State believes that effective coordination between the mental health and child welfare systems must include the following essential components:

Written procedures for coordinating services for individual consumers and their families; and a written Memorandum of Understanding (MOU) between the contractor and each county department of social/human services in the contractor's service area." [49]

And

The RFP2000 requires the contractor to coordinate mental health services with the Juvenile Justice System:

"The contractor shall be responsible for providing mental health services to Medicaid-eligible children and adolescents in the custody of the Colorado Division of Youth Corrections." [50]

"The contractor shall enter into a Memorandum of Understanding (MOU) with the Colorado Division of Youth Corrections and Colorado Mental Health Services to facilitate coordination of services." [51]

And

[49] *RFP2000 Section III-70-A. Attachment A.II.e.2.*
[50] *RFP2000 Section III-70-D. Attachment A.II.e.2.*
[51] *RFP2000 Section III-70-D. Attachment A.II.e.2.*

The RFP2000 requires the contractor to coordinate mental health services with the Criminal Justice System:

"The contractor shall comply with the terms of the Memorandum of Understanding between Colorado Mental Health Services and the Colorado Department of Corrections." [52]

And

The RFP2000 requires the contractor to coordinate mental health services with educational systems:

"The contractor shall make reasonable efforts to coordinate with the educational system for the provision of services to school-age children and adolescents. This should include coordination with services provided under Individualized Education Plans (IEPs) and with Part H of the Individuals with Disabilities Education Act (IDEA). Coordination also may include working with teachers and school administrators to:

- *provide services in schools;*
- *identify mental health issues that may be affecting a child or adolescent's progress in school;*
- *identify ways in which the school can assist in the child or adolescent's treatment;*
- *educate teachers and administrators about mental health, emotional and behavioral disorders that affect children and adolescents and provide resource materials to schools; and*
- *develop other appropriate strategies for coordination and collaboration.*

The contractor shall work with the educational systems in its service area to coordinate services at the agency level, and to coordinate services to individual consumers." [53]

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[52] *RFP2000 Section III-70-E. Attachment A.II.e.2.*
[53] *RFP2000 Section III-70-F. Attachment A.II.e.2.*

VII. Attachments

Chart Based Outcome Protocol Report FY01 & FY02. Attachment B.VI.b.

Program Quality Monitoring Protocol FY02 & FY03. Attachment B.VI.b.

Section C. Quality of Care and Services

A Section 1915(b) waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs which utilize ~~MCOs or~~ PIHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies

This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

~~**a.**___ During the last waiver period, the Elements of State Quality Strategies were different than described in the waiver governing that period. The differences were:~~

b.✔ [Required] Describe the results of monitoring ~~MCO~~/PIHP adherence to State standards for internal Quality Assurance Programs during the previous two-year period [item C.I.b in 1999 initial preprint; Item B.1 in 1995 preprint].

The State has required that all PIHPs meet State standards for Internal Quality Assurance Programs as outlined in the RFP2000 [54] and State Regulations. [55] The State has monitored all PIHPs' adherence to these standards, through the following mechanisms:

- *An annual review of each plan's written QAP description to monitor compliance with the State's QAP standards.*
- *Periodic review of data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population.*
- *On-site monitoring of the QAP to assure compliance with the State's QAP standards.*

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[54] *RFP2000 Section III-88. Attachment A.II.e.2.*
[55] *Rules and Regulations for the Colorado Public Mental Health System, Attachment C.I.b.*

The State requires an annual update to the QAP descriptions and in it's monitoring has continued to approve all contractor's QAPs. Each contractor has met the State's requirements for QAPs and has to varying degrees completed activities to monitor quality of care, clinical outcomes and consumer satisfaction.

In addition to approving the contractors' QAP, the State requires each PIHP to conduct a program evaluation to determine the extent to which the MHASA is meeting the mental health care needs of the Medicaid population for which it is contracted to serve. The PIHPs submitted their initial plans describing how they would determine the extent to which the mental health needs were being met in 1998. They have submitted annual evaluations to the State since that time. Each evaluation was based on the original plan and built on the deficiencies identified in the prior evaluations. In 2002, the State required the PIHPs to submit updated plans.

In FY'01, the PIHPs' reviewed a variety of indicators to assess the extent to which they were meeting the mental health needs of the Medicaid population. A sample of the strengths that were identified included increases in the 30-day follow-up after inpatient discharge and a decrease in hospital readmission rates in the Denver area. In the SyCare – Options PIHP, satisfaction survey results increased from the prior year in the San Luis Valley Community Mental Health Center. Additional services were added targeting families of children at risk on the West Slope. Increases in consumer satisfaction were noted in the Jefferson PIHP. Some of the identified improvement opportunities included the need to implement a centralized scheduling system at Jefferson to improve routine access to services. Northeast Behavioral Health (NBH) concluded that they needed to coordinate efforts at their three Community Mental Health Centers to identify factors that would lead to increased parental involvement in the treatment process. Behavioral HealthCare, Inc. noted that consumers consistently expressed the need for more vocational opportunities and implemented an on-the-job training and vocational support program.

In FY '02, some of the identified strengths included increased penetration rates, a continued downward trend in 30-day readmission rates, and improvement in seven and 30-day follow-up after inpatient discharge rates in the Denver area. Routine appointment access improved at the Jefferson PIHP and an urgent and emergency access tracking mechanism was implemented. Survey responses to a NBH administered survey indicated that they were providing culturally appropriate care. Some of the improvement opportunities identified included the need improve data

collection in Denver and the need to have staff work with consumers to help them understand admission paperwork at NBH.

The plans for FY '03, as well as the FY '01 and '02 evaluations, have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).

~~c.___ [Required for MCOs] Summarize the results of reports from the External Quality Review Organization. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint].~~

d.✔ [Required for PIHPs ~~and MCOs~~] Describe the results of periodic medical audits, and any follow-up done/planned to address audit findings [item C.I.d in 1999 initial preprint; item B.3 in 1995 preprint].

Medical chart audits are conducted during Program Quality (PQ) Site Reviews. The results of Medicaid monitoring for this waiver period are summarized in the attached Chart Based Outcome Protocol Report FY 01 & 02. [56] *Program Quality Site Review reports have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). When the site visit results identify the need for corrective action, the State requests that a corrective action plan be developed. The State reviews and approves the corrective action plan and follow-up to ensure that it is implemented.*

There are currently two areas that are receiving close scrutiny in the site review process. Program Quality staff at their site reviews are stressing the importance of strength/recovery based service planning. Charts must contain goals and measures that are strength/recovery based. Although not currently a compliance issue, evidence of culturally appropriate treatment in the charts is also being stressed.

~~e.___ [MCOs only] Intermediate sanctions were imposed during the previous waiver period. Please describe.~~

Upcoming Waiver Period -- Please check any of the items below that the State requires. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks

[56] *Chart Based Outcome Protocol Report FY01 and FY02. Attachment B.VI.b.*

(i.e., "**") after your response. Note: Elements a - g are requirements for States. Elements c, d and e are required for States which contract with MCOs and element d is required for States which contract with PIHPs. The State:

a. ✔ Includes in its contracts with ~~MCOs~~/PIHPs, the State-required internal QAP standards. Please submit a copy of the State's Quality Assurance and Performance Improvement (QAPI) standards and/or guidelines currently required of ~~MCOs~~/PIHPs in their contracts as *noted below* ~~an attachment to this section (Attachment C.I.a)~~.

The RFP2000 contains the following standards/guidelines for Quality Assurance Programs:

"The contractor shall have a Quality Improvement Program that is designed to enhance the quality of services provided to consumers and other stakeholders. The contractor shall utilize commonly accepted health care quality improvement methods and standards in assessing both administrative systems and clinical interventions.

The Quality Improvement Program shall:

- *be developed with input from consumers and family members;*
- *evaluate the outcomes of the services provided, by determining whether the quality of consumers' and families' lives have been maintained or improved as a result of receiving services;*
- *include an annual evaluation to determine the extent to which the contractor has identified and met the mental health care needs of the enrolled population, and to identify any unmet needs for mental health services;*
- *include benchmarks of clinical quality determined through outcome measures, such as readmission rates, reduced symptomology, indicators of recovery, and improved quality of life;*
- *include methods for monitoring administrative processes, such as phone access times, service access, claims processing and payment, network adequacy, penetration rates and complaints; and*
- *use results of quality improvement activities to plan and improve the contractor's administrative systems and clinical services.*

The contractor shall document its Quality Improvement efforts and make information on Quality Improvement activities and results available to consumers, families and other stakeholders." [57, 58]

b. ✔ Monitors, on a continuous basis, ~~MCOs~~/PIHPs adherence to the State standards, through the following mechanisms (check all that apply):

1. ✔ Review and approve each ~~MCOs~~/PIHPs written QAP. Such review shall take place prior to the State's execution of the contract with the ~~MCO~~/PIHP.

2. ✔ Review each ~~MCOs~~/PIHPs written QAP on a periodic schedule after the execution of the contract. Please specific frequency:

   The RFP2000 requires the contractor to submit an annual QAP description and work plan in addition to quarterly reports regarding its QAP activities:

   "The contractor shall submit quarterly reports to the State on its quality improvement activities, and shall make quarterly reports available to consumers, families and other stakeholders.

   The contractor shall submit an Annual Quality Improvement Plan to the State. The Plan shall include:

   - *a QI Program Description outlining the administrative structure and operation of the QI Program; and*
   - *a QI Work Plan describing the planned activities for the year, the timeline for completion of those activities, and the staff member responsible for implementing each activity.*

   The Annual Quality Improvement Plan is subject to approval by the State." [59]

[57] *RFP2000 Section III-88. Attachment A.II.e.2.*
[58] *Specific Performance Indicators are included in Section C.VII.c of this document*
[59] *RFP2000 Section III-88. Attachment A.II.e.2.*

3. ✔ ~~On-site~~ (~~MCO~~/PIHP administrative offices or service delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's Quality standards. Such monitoring will take place (specify frequency) *annually*** for each ~~MCO~~/PIHP ~~or attach the scope of work from the EQRO contract as an attachment to this section~~.

4. ✔ Conducts monitoring activities using (check all that apply):

~~(a) State Medicaid agency personnel~~

(b) ✔ Other State government personnel (please specify):

Monitoring is done by the Medicaid Capitation Team and Program Quality Team of Mental Health Services, Office of Behavioral Health and Housing, the agency granted monitoring authority through an MOU with the State Medicaid Agency (HCPF).

~~(c) A non-State agency contractor (please specify):~~

~~5. Other (please specify):~~

c. ✔ Will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered under each ~~MCO~~ contract with the State. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area.

1. Please specify the name of the entity:

The State plans to contract with an External Quality Review Organization (EQRO) to review the quality, outcomes, and timeliness of, and access to the services provided by each of the eight contractors operating the Mental Health Capitation Program. The EQRO has not been selected yet.

2. The entity type is:

(a) ✔ A Peer Review Organization (PRO).
(b) __ A private accreditation organization approved by HCFA.

(c) __ A PRO-like entity approved by HCFA.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):

The EQRO will review the quality, outcomes, and timeliness of, and access to the services provided by each of the eight contractors operating the Mental Health Capitation Program. The State is reviewing the feasibility of using protocols that are under consideration in the proposed EQRO regulation. The specific protocols under consideration are:

- *Contractor Compliance with Federal Medicaid Managed Care Regulations*
- *Performance Measurement*
- *Performance Improvement Projects*

*Until the proposed regulations containing these protocols are approved and become effective, the State may choose to meet the EQRO requirement by having the EQRO follow these protocols, or by establishing other methods for the EQRO to review the quality, outcomes, and timeliness of, and access to the services provided by each contractor operating the Mental Health Capitation Program.***

d. ✔ Has established a system of periodic medical audits of the quality of, and access to, health care for each ~~MCO~~/PIHP on at least an annual basis. These audits will identify and collect management data (including enrollment and termination of Medicaid enrollees and utilization of services) for use by medical audit personnel. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area. States may, at their option, institute EQR reviews for PIHPs. These periodic medical audits will be conducted by:

1. The entity type is:

~~(a) __ State Medicaid agency personnel~~

(b) ✔ Other State government personnel (please describe):

Mental Health Services is the state agency charged with performing periodic medical audits. Agency staff are experienced B.A., M.A.,

and Ph.D. professionals specializing in the fields of mental health, quality assurance, and program management:

"… the State shall have the right to access all contractor information, including confidential clinical information, pertaining to consumers served under the contract. Upon request, the contractor shall provide clinical records and/or other information, or otherwise make requested materials available for State inspection, without a written release from the consumer.

Colorado Mental Health Services will monitor the provision of services by reviewing a sample of clinical records." [60]

~~(c)__ A non-State agency contractor to the State (please describe):~~

~~(d)__ Other (please describe):~~

2. Please attach the scope of work for the periodic medical audits.

The protocol document for FY '02 and '03 is contained in attachment B.VI.b.

~~**e.**__ Has established intermediate sanctions that it may impose if the State makes a determination that an MCO violates one of the provisions below. (Note: does not apply to PIHPs).~~

f.✔ Has an information system that is sufficient to support initial and ongoing operation and review of the State's QAPI.

g.✔ Has standards in the State QAPI, at least as stringent as those required in federal regulation, for access to care, structure and operations, quality measurement and improvement and consumer satisfaction.

~~**h.**__ Plans to develop and implement the use of QISMC in its quality oversight of MCOs/PIHPs? (QISMC is a HCFA initiative to strengthen MCOs/PIHPs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. The QISMC standards and guidelines are key tools that can be used by HCFA and States in implementing the quality assurance provisions of the Balanced Budget Act (BBA) of 1997. This is~~

[60] *RFP2000 Section III-92-A. Attachment A.II.e.2.*

~~strictly a voluntary initiative for States). Please explain which domains will the State be implementing (check all that apply).~~

~~1.__ Domain 1 - Quality Assessment and Performance Improvement (QAPI) Program: Date of Implementation _____~~

~~2.__ Domain 2 - Enrollee Rights: Date of Implementation _____~~

~~3.__ Domain 3 - Health Services Management : Date of Implementation _____~~

~~4.__ Domain 4 - Delegation: Date of Implementation _____~~

~~**i.**__ Other (please describe)**:**~~

II. Coverage and Authorization of Services

Previous Waiver Period

~~**a.**___ During the last waiver period, coverage and authorization of services were different than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.

Coverage and authorization of services have been monitored during this waiver period through the State's complaint reporting system and medical chart audits. The annual complaint summary reports for FY '01 and '02 have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). Program Quality site review results have been submitted periodically during the waiver period to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). Program Quality staff, at their site reviews, review medical records to ensure that the treatment provided was appropriate for the diagnosis. The findings to date indicate that it is rare the appropriate services have not been provided.

Upcoming Waiver Period -- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting ~~MCOs~~/PIHPs meet coverage and authorization requirements. For items a through e, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Contracts with ~~MCOs~~/PIHPs:

a. ✔ Identify, define and specify the amount, duration and scope of each service offered, differentiating those services, which may be only available to special needs populations, as appropriate.

b. ✔ Specify what constitutes "medically necessary services" consistent with the State's Medicaid State Plan program (i.e., the FFS program). Please list that specification or definition:

A. A covered service shall be deemed medically or clinically necessary if, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care, the service:

1. is reasonably necessary for the diagnosis or treatment of a covered mental health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder; and

2. is furnished in the most appropriate and least restrictive setting where services can be safely provided; and

3. cannot be omitted without adversely affecting the consumer's mental and/or physical health or the quality of care rendered;

B. The contractor, in consultation with the service provider, consumer, family members, and/or person with legal custody shall determine the medical and/or clinical necessity of the covered service.

C. The authorization process shall take into consideration other factors, such as the need for services and supports to assist a consumer to gain new skills or regain lost skills, that support or maintain functioning and promote recovery.

D. The contractor shall not deny services based on medical or clinical necessity solely because the consumer has a poor prognosis or has not shown improvement, if the covered services are necessary to prevent regression or maintain present condition.[61]

c. ✔ Provide that the ~~MCO~~/PIHP furnishes the services in accordance with the specification or definition of "medically necessary services".

d. ✔ Ensure implementation of written policies and procedures reflecting current standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. Policies include:

1. ✔ Specific time frames for responding to requests,

2. ✔ Requirements regarding necessary information for authorization decisions,

3. ✔ Provisions for consultation with the requesting provider when appropriate,

4. ✔ Providing for expedited response for urgently needed services

5. ✔ Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals.

6. ✔ Criteria for decision on coverage and medical necessity are updated regularly.

7. ✔ Mechanisms to ensure consistent application of review criteria and compatible decisions.

8. ✔ A process for clinical peer reviews of decisions to deny authorization of services on the grounds of medical appropriateness.

[61] *RFP2000 Section III-35. Attachment A.II.e.2.*

9. ✔ Processes and procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services. (Note: current regulations require notice for a termination, reduction, or suspension of services which have already been authorized or when a claim for services is not acted upon with reasonable promptness. This check box should be marked when the State also requires notice when an enrollee's request for future services is denied, limited, or discontinued.) Notices include (check all that apply):

(a) ✔ Criteria used in denying or limiting authorization

(b) ✔ Information on how to request reconsideration of the decision.

~~(c) Other (please describe):~~

10. ✔ Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

11. ✔ Mechanisms to detect both underutilization and over utilization of services.

~~12. Other (please describe):~~

~~**c.** Other (please describe):~~

III. Selection and Retention of Providers

Previous Waiver Period

~~**a.** During the last waiver period, the selection and retention of providers were different than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State monitored the process for selection and retention of providers checked in

the previous waiver submittal [items C.III.a-h in the 1999 initial preprint; relevant sections of the 1995 preprint]. Also please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period.

The RFP2000 requires that the PIHPs have a credentialing and recredentialing process in place:

"The contractor shall have a system to credential providers prior to including providers in its provider network. This shall include:

- *written policies and standards for credentialing and re-credentialing different types of providers, including both provider organizations (e.g. hospitals, clinics, CMHCs, etc.) and individual practitioners (e.g. psychiatrists, psychologists, social workers, nurses, etc.); and*
- *written procedures for the credentialing and re-credentialing processes.*

The credentialing and re-credentialing policies and standards shall include, at a minimum, the following:

- *review of each provider prior to the provider seeing contractor clients, and at least every three (3) years thereafter;*
- *the scope of practitioners covered;*
- *the criteria used to make credentialing decisions;*
- *the process used to make credentialing decisions;*
- *the process for provider notification of credentialing action;*
- *time frames for the credentialing and provider notification processes;*
- *the extent to which any delegation of credentialing occurs;*
- *the right of providers to review their credentialing files;*
- *the provider's right to correct erroneous information;*

- *how Community Mental Health Centers and hospitals are credentialed;*
- *the appointment of credentialing committee members; and*
- *the process used to protect confidentiality.*

The credentialing and re-credentialing procedures shall include, at a minimum, the following:

- *review of complaints against the provider;*
- *primary verification of licensure and certification;*
- *primary verification of training and education;*
- *primary verification of experience;*
- *primary verification of malpractice history;*
- *upon application, signed attestation including reasons for inability to perform essential functions, lack of present illegal drug use, history of loss of license, and correctness and completeness of application;*
- *site visit to assess access for persons with disabilities, availability of appointments, and clinical record keeping practices for defined high-volume providers; and*
- *review of previous sanctions by Medicaid or Medicare.*

Primary source verification is not necessary if the following parameters are met:

Training and Education:

- *Verification of medical board certification fully meets this requirement.*
- *Non-physician specialty boards and registries may be used if those sources use primary source verification. The contractor must obtain written confirmation annually that the board or registry uses primary source verification.*
- *Verification of completion of residency meets the requirement.*

- *If there is no residency or the provider has not completed residency, then verification of graduation from medical or professional school meets the requirement. Multiple sources are available to verify the requirements.*

Professional Experience:

- *The contractor must obtain a five-year work history, through the practitioner's application, or curriculum vitae (equal to application attestation). Gaps of six months need to be verified (verbally); if a gap exceeds one year, clarification should be in writing.*

Malpractice History:

- *The contractor must either obtain written confirmation of the past five years of history of malpractice settlements from the malpractice carrier or query the NPDB.*

The credentialing and re-credentialing policies, standards and processes, including the time frames for completing the process, shall be comparable to those of the managed behavioral health care industry, and are subject to approval by the State.

Credentialing and re-credentialing policies, standards and processes shall, at a minimum, apply to the following types of providers in the contractor's network:

- *physicians;*
- *licensed doctoral and master level psychologists;*
- *licensed social workers;*
- *clinical nurse specialists;*
- *psychiatric nurse practitioners; and*
- *any other licensed or certified professionals."* [62]

The Medicaid Mental Health Capitation Team reviewed each contractors' credentialing and recredentialing policies and procedures in FY '02 for

[62] *RFP2000 Section III-19. Attachment A.II.e.2.*

compliance with the RFP2000 requirements listed above. As a result of the review, corrective actions were required of two PIHPs. Detailed results of this review and the subsequent corrective actions have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).

Upcoming Waiver Period

Please check any processes or procedures listed below that the State uses to ensure that each ~~MCO~~/PIHP implements a documented selection and retention process for its providers. For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires ~~MCOs~~/PIHPs to (please check all that apply):

~~**a.**___ Develop and implement a documented process for selection and retention of providers.~~

b.✔ Have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

c.✔ Have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1.✔ Initial credentialing

~~2.___ Performance indicators, including those obtained through the following (check all that apply):~~

~~(a)__ The quality assessment and performance improvement program~~
~~(b)__ The utilization management system~~

~~(c)__ The grievance system~~

~~(d)__ Enrollee satisfaction surveys~~

~~(e)__ Other MCO/PIHP activities as specified by the State.~~

d. ✔ Use formal selection and retention criteria that do not discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

e. ✔ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State

The RFP2000 requires the contractors to establish a credentialing process for individual and institutional providers:

"The contractor shall have a system to credential providers prior to including providers in its provider network. This shall include:

- *written policies and standards for credentialing and re-credentialing different types of providers, including both provider organizations (e.g. hospitals, clinics, CMHCs, etc.) and individual practitioners (e.g. psychiatrists, psychologists, social workers, nurses, etc.); and*

- *written procedures for the credentialing and re-credentialing processes.*

The credentialing and re-credentialing policies and standards shall include, at a minimum, the following:

- *review of each provider prior to the provider seeing contractor clients, and at least every three (3) years thereafter;*

- *the scope of practitioners covered;*

- *the criteria used to make credentialing decisions;*

- *the process used to make credentialing decisions;*

- *the process for provider notification of credentialing action;*

- *time frames for the credentialing and provider notification processes;*

- *the extent to which any delegation of credentialing occurs;*
- *the right of providers to review their credentialing files;*
- *the provider's right to correct erroneous information;*
- *how Community Mental Health Centers and hospitals are credentialed;*
- *the appointment of credentialing committee members; and*
- *the process used to protect confidentiality.*

The credentialing and re-credentialing procedures shall include, at a minimum, the following:

- *review of complaints against the provider;*
- *primary verification of licensure and certification;*
- *primary verification of training and education;*
- *primary verification of experience;*
- *primary verification of malpractice history;*
- *upon application, signed attestation including reasons for inability to perform essential functions, lack of present illegal drug use, history of loss of license, and correctness and completeness of application;*
- *site visit to assess access for persons with disabilities, availability of appointments, and clinical record keeping practices for defined high-volume providers; and*
- *review of previous sanctions by Medicaid or Medicare.*

The credentialing and re-credentialing policies, standards and processes, including the time frames for completing the process, shall be comparable to those of the managed behavioral health care industry, and are subject to approval by the State.

Credentialing and re-credentialing policies, standards and processes shall, at a minimum, apply to the following types of providers in the contractor's network:

- *physicians;*
- *licensed doctoral and master level psychologists;*
- *licensed social workers;*
- *clinical nurse specialists;*
- *psychiatric nurse practitioners; and*
- *any other licensed or certified professionals."* [63]

f. ✔ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

~~**g.** ___ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.~~

~~**h.** ___ Other (please describe):~~

IV. Delegation

Previous Waiver Period

~~**a.** ___ During the last waiver period, delegation was different than described in the waiver governing that period. The differences were:~~

b. ___ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

The State has reviewed and approved sample contracts from the contractors.

[63] *RFP2000 Section III-19. Attachment A.II.e.2.*

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting ~~MCOs~~/PIHPs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Where any functions are delegated by ~~MCOs~~/PIHPs, the State Medicaid Agency:

a. ✔ Reviews and approves (check all that apply):

~~1. ___ All subcontracts with individual providers or groups~~

2. ✔ All model subcontracts and addendums

~~3. ___ All subcontracted reimbursement rates~~

~~4. ___ Other (please describe):~~

b. ✔ Requires agreements to be in writing and to specify any delegated responsibilities.

c. ✔ Requires agreements to specify reporting requirements.

d. ✔ Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

e. ✔ Monitors to ensure that ~~MCOs~~/PIHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

f. ✔ Ensures that ~~MCOs~~/PIHPs monitor the performance of the entity on an ongoing basis.

g. ✔ Monitors to ensures that ~~MCOs~~/PIHPs formally review the entity's performance at least annually.

h. ✔ Ensures that ~~MCOs~~/PIHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

~~**i.** Other (please explain):~~

V. Practice Guidelines

Previous Waiver Period

~~**a.** During the last waiver period, practice guidelines were different than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

Practice guidelines were implemented during the previous waiver period. The State has not yet monitored compliance in this area, but plans to in the upcoming waiver period.

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that contracting ~~MCOs~~/PIHPs adopt and disseminate practice guidelines (please check all that apply). For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Guidelines:

a. ✔ Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.

b. ✔ Consider the needs of the ~~MCOs~~/PIHPs enrollees.

c. ✔ Are developed in consultation with contracting health professionals.

d. ✔ Are reviewed and updated periodically.

e. ✔ Are disseminated to all providers, all enrollees (as appropriate) and individual enrollees upon request.

f. ✔ Are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g. ✔ Develop and implement policies and procedures for evaluating new medical technologies and new uses of existing technologies.

~~**h.** Other (please explain):~~

VI. Health Information Systems

Previous Waiver Period

~~**a.** During the last waiver period, health information systems of contracting MCOs/PIHPs were different than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

Through the end of FY '02 (July, 2002) contractors were in compliance with IS submissions. A number of contractors are replacing legacy systems with HIPAA compliant software and that has resulted in delays in data submissions in some cases. Mental Health Services is aware of each contractor's situation and communicates regularly with the contractors.

The data submitted to the State in the previous waiver period provided information on utilization as well as enrollee and provider characteristics. Complaint and grievance data was submitted to the State and annual reports were prepared for FY '01 and FY '02. These reports have been submitted to the CMS Denver Regional Office.

c. ✔ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by ~~MCOs~~/PIHPs.

The State's Encounter data system is based on the HCFA1500 and UB-92 billing forms. Contractors submit monthly electronic data tapes or diskettes to Mental Health Services. The Data and Evaluation Team at Mental Health Services, in cooperation with the Capitation Program's financial analyst review the data for duplicate counts and missing data and create the program's encounter data reports. As described above, with the implementation of new data systems, some FY '03 data have not been submitted. Prior to FY '03 and the accompanying change in data systems, contractors submitted required data in a timely fashion. Any erroneous data discovered by Mental Health Services after submission were sent back to the contractor for re-submission.

d. ✔ The State uses information collected from ~~MCOs~~/PIHPs as a tool to monitor and evaluate ~~MCOs~~/PIHPs ~~(i.e. report cards)~~. Please describe.

Colorado Client Assessment Record (CCAR) and Encounter data are used in monitoring the Performance Indicators that the State uses as "standardized quality measures." Information contained in these databases reflect demographics, administrative information, clinical profiles, and utilization. These data have been collected since the advent of capitation in Colorado. This allows the examination of trends and evaluation of contractor performance longitudinally. See Section C.VII.c for additional information.

~~**e.** ___ The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PIHPs and/or providers). Please describe.~~

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting ~~MCOs~~/PIHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that ~~MCOs~~/PIHPs systems:

a. ✔ Provide information on

1. ✔ Utilization,
2. ✔ Grievances,

~~3.___ Disenrollment.~~

b. ✔ Collect data on enrollee and provider characteristics as specified by the State.

c. ✔ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe).

The RFP2000 outlines the scope of the encounter data system required by the State:

"The contractor shall submit Medicaid claim forms for each service provided to each consumer under the Program.

The UB-92 claim form shall be used for all inpatient and other 24-hour services, and for all outpatient hospital services. Document 13 in the Procurement Library contains the UB-92 claim form, record layout, edit criteria, and reporting requirements.

The Colorado-1500 claim form shall be used for all other (non-hospital outpatient and less than 24 hour) services. This form is very similar to the commonly used HCFA-1500 form, and contains only minor differences from the HCFA-1500 form. Document 14 in the Procurement Library contains the Colorado-1500 claim form, record layout, edit criteria and reporting requirements.

The contractor shall submit all encounter data to the State on a monthly basis, according to a schedule determined by the State. Data shall be submitted electronically in a format prescribed by the State. Encounter data shall be due approximately ninety (90) days after the date of service, or third party payment or denial. Documents 13 and 14 in the Procurement Library contain schedules for reporting encounter data.

The contractor may subcontract with service providers who are not enrolled in the Medicaid Program. The Medicaid Management Information System operated by the Medicaid Fiscal Agent will assign a unique Medicaid Encounter Only provider number to each non-Medicaid service provider. The contractor shall ensure that providers use these identification numbers when reporting encounter data." [64]

[64] *RFP2000 section III-90-D. Attachment A.II.e.2.*

The ~~MCO~~/PIHP is capable of (please check all that apply):

1. ✔ [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees
2. ✔ [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors
3. ✔ Verifying the accuracy and timeliness of data
4. ✔ Screening data for completeness, logic and consistency
5. ✔ Collecting service information in standardized formats to the extent feasible and appropriate
6. ~~Other (please describe):~~

d. ✔ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1. ~~Health services (please specify frequency and provide a description of the data and/or content of the reports)~~
2. ✔ Outcomes of *mental* health care (please specify frequency and provide a description of the data and/or content of the reports)

   Outcome data is examined annually in the "Summary Report of Client Characteristics" which documents consumer demographics, consumer clinical information and discharge data.
3. ✔ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)

   Encounter data reports are submitted electronically each month by the contractors. An annual report is compiled within ninety days of the end of the fiscal year as a part of an audited report from the contractor.

~~4.___ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)~~

e.✔ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAP.

f.✔ Ensure that information and data received from providers are accurate, timely and complete.

PIHPs must certify the accuracy, completeness, and truthfulness of the data submitted to the State.

g.✔ Allow the State agency to monitor the performance of ~~MCOs~~/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.

h.✔ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

~~**i.**___ Other (please describe):~~

VII. Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

~~**a.**___ During the last waiver period, the State's Quality Assessment and Performance Improvement (QAPI) program was different than described in the waiver governing that period. The differences were:~~

b.✔ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint]. Please break down monitoring results by subpopulations if available.

The State reviews and approves the PIHPs' quality improvement program descriptions and workplans annually. The criteria used for review of the program descriptions are the required elements in the RFP2000 as well as industry best practices. The RFP2000 states:

"The Quality Improvement Program shall:

- *be developed with input from consumers and family members;*
- *evaluate the outcomes of the services provided, by determining whether the quality of consumers' and families' lives have been maintained or improved as a result of receiving services;*
- *include an annual evaluation to determine the extent to which the contractor has identified and met the mental health care needs of the enrolled population, and to identify any unmet needs for mental health services;*
- *include benchmarks of clinical quality determined through outcome measures, such as readmission rates, reduced symptomology, indicators of recovery, and improved quality of life;*
- *include methods for monitoring administrative processes, such as phone access times, service access, claims processing and payment, network adequacy, penetration rates and complaints; and*
- *use results of quality improvement activities to plan and improve the contractor's administrative systems and clinical services.*

The contractor shall document its Quality Improvement efforts and make information on Quality Improvement activities and results available to consumers, families and other stakeholders.

The contractor shall submit an Annual Quality Improvement Plan to the State. The Plan shall include:

- *a QI Program Description outlining the administrative structure and operation of the QI Program; and*
- *a QI Work Plan describing the planned activities for the year, the timeline for completion of those activities, and the staff member responsible for implementing each activity.*

The Annual Quality Improvement Plan is subject to approval by the State."[65]

[65] *RFP2000 Section III-88. Attachment A.II.e.2.*

The PIHPs' performance is assessed against the standardized quality measures described in Section C.VII.c. Upcoming Waiver Period. The most recent results are attached. [66]

In addition, the State required each contractor to conduct an annual Program Evaluation to determine the extent to which the contractor has identified and met the mental health care needs of the Medicaid population. A brief summary of the results of the contractors' Program Evaluation projects is contained in Section C.I.b. The FY'01 and '02 Program Evaluations and the PIHPs' FY '03 Program Evaluation Plans have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).

c. ✔ The State or its ~~MCOs~~/PIHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two-year period.

Please see Section VII.b. Previous Waiver Period above.

Upcoming Waiver Period- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting ~~MCOs~~/PIHPs maintain an adequate QAPI. For items a through u, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that ~~MCOs~~/PIHPs (check all that apply and note in narratives if the State intends to break down the results by subpopulation):

a. ✔ Have an adequate organizational structure which allows for clear and appropriate administration and evaluation of the QAPI. The State has standards which include (check all that apply):

~~1.___ A policy making body which oversees the QAPI~~

[66] *PIHPs' Performance Indicator Results FY' 01 and '02. Attachment C.VII.c.*

2. ✔ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3. ✔ Active participation by providers and consumers

4. ✔ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

~~5. Other (please describe):~~

b. ✔ Measure their performance, using standard measures established or adopted by the State Medicaid agency, and reports their performance to the applicable agency. Please list or attach the standard measures currently required.

See, Section C.VII.c below for the performance standards written into the RFP2000.

c. ✔ Achieve required minimum performance levels, as established by the State Medicaid agency on standardized quality measures. Please list or attach the standardized quality measures established by the State Medicaid agency.

The RFP2000 contains the following Performance Indicators that are used as "standardized quality measures"

"The State of Colorado is implementing a new Performance Indicator System under this contract. This system includes:

- *16 indicators that will be used to evaluate the contractor's performance in a number of critical areas;*
- *6 additional indicators that are still under development, and that will be used to evaluate the contractor's performance in future years; and*
- *a financial incentive system that will award incentives based on the contractor's performance as measured by selected performance indicators.*

By submitting a proposal in response to this RFP, offerors agree to participate in the Performance Indicator System described in this section of the RFP.

The following table summarizes the performance indicators that will be used under this contract:" [67]

PERFORMANCE INDICATOR	DEFINITION	MEASURE
Access Indicators		
1. Penetration Rate	% of Program enrollees served during the year	Encounter Data
2. Consumer Perception of Access	% of consumers agreeing with access items	MHSIP Survey
Quality Indicators		
3. Consumer/Family Participation in Service Planning	% of consumers reporting involvement in service planning	MHSIP Survey
4. Services After Hospital Discharge	% of consumers who receive one or more non-emergency outpatient mental health service within 7 days of hospital discharge	Encounter Data
5. Treatment of Persons with MH and SA Diagnoses	% of consumers who have both mental health and substance abuse diagnoses	CCAR
6. Consumer Perception of Quality	% of consumers agreeing with quality items	MHSIP Survey
Outcome Indicators		
7. Improvement in Employment	% of adult consumers going from unemployed at initial or previous assessment to employed at next assessment	CCAR
8. Maintained Employment	% of adult consumers employed at initial or previous assessment who are still employed at next assessment	CCAR
9. Improvement in School Performance	% of children and adolescents showing improvement from initial or previous assessment to next assessment	CCAR
10. Increased Level of Functioning	% of consumers showing improvement from initial or previous assessment to next assessment	CCAR
11. Maintained Level of Functioning	% of consumers showing less than a 10% change in level of functioning from initial or previous assessment to next assessment	CCAR
12. Consumer Perception of Outcomes	% of consumers agreeing with outcome items	MHSIP Survey
13. Independent Living / Services to Homeless Persons	% of adults living independently, and % of homeless adults receiving services	CCAR
14. Increased Strengths and Resources	% of consumers showing improvement from initial or previous assessment to next assessment	CCAR
15. Consumer Satisfaction with Services	% of consumers agreeing with satisfaction items	MHSIP Survey
Management Indicators		
16. Administrative Costs	% of Program revenue spent on administration	Audits
Developmental Indicators		

[67] *RFP2000 Section III-87. Attachment A.II.e.2.*

PERFORMANCE INDICATOR	DEFINITION	MEASURE
17. Primary Care	% of consumers who had at least one non-emergency face-to-face contact with PCP in the last year	Under Development
18. Child/Parent/Guardian Satisfaction with Services	% of families satisfied with services	Under Development
19. Recovery/Hope/Empowerment	Under Development	Under Development
20. Adults Receiving Atypical Medications	% of adults with serious mental illness receiving new generation antipsychotics	Under Development
21. Supported Employment	% of adult consumers receiving supported employment services	Under Development
22. Participation on Decision Making Boards and Committees	number of consumers and family members serving on governing boards, planning committees, and other decision-making bodies	Under Development

Mental Health Services instituted a monetary incentive system for the contractors in the current waiver period. The choice of indicators is the result of numerous meetings between Mental Health Services' capitation staff, other Mental Health Services' staff, contractors, consumers, and advocates. This system was fully implemented with payouts starting in FY '01. The indicators used for the first award period were:

- *penetration rates for children/adolescents and adults/older adults;*
- *change in problem severity;*
- *employment; and*
- *five domains from the MHSIP consumer survey.*

The results of this analysis are contained in Attachment C.VII.c. Any contractor who was above the median score in a category was awarded an amount that was proportional to the size of the eligible population for the catchment area.

In FY '02 additional indicators were included in the incentive system measures. The indicators for FY '02 were those used for FY '01, plus measures for adults living independently and children living in a family-like setting. In contrast to FY '01, funds were awarded based on a point system where a contractor that received more points was ranked higher compared to the other contractors on each indicator. All contractors received at least one point; i.e., the last ranked PIHP received one point. Details of the results of the FY '02 incentive system are contained in Attachment C.VII.c. Mental Health Services continues to seek appropriate benchmarks or standards to which to compare performance.

d. ✔ Conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be

expected to have a beneficial effect on health outcomes and enrollee satisfaction.

Please list the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

The following is a list of performance improvement projects that the PIHPs are working on in FY '03. Due to the dynamic nature of quality improvement, projects will vary from year-to-year as issues are identified. The PIHPs performance improvement projects are contained in their QI Program Descriptions and Workplans that they submit to the State annually for approval.

- *Clinical practice improvement – compliance with treatment guidelines for schizophrenia and ODD in children*
- *Compliance with ADHD guideline*
- *Evaluate outcome indicators/changes over time using CCAR and CROS*
- *Improve access to care*
- *Improve consumer satisfaction survey and process*
- *Improve employee satisfaction*
- *Clinical focus on strengthening the use of DBT in the treatment of borderline personality disorder*
- *Improve access to medication evaluations*

e. ✔ Correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

f. ✔ Are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

g. ✔ Are allowed to conduct multi-year projects that meet the improvement standards as described in QISMC or that are specified in a project work plan developed in consultation with the State Medicaid agency.

h. ✔ Select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

i. ✔ Select and prioritize topics for projects to achieve the greatest practical benefit for enrollees.

j. ✔ Select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

k. ✔ Provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

l. ✔ Assess and measure the organization's performance for each selected topic using one or more quality indicators.

m. ✔ Base the assessment of the organization's performance on systematic, ongoing collection and analysis of valid and reliable data.

n. ✔ Establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

o. ✔ Use a sampling methodology that ensures that results are accurate and reflective of the ~~MCOs~~/PIHPs enrolled Medicaid population.

p. ✔ Meet previously-determined standards to define results that show significant demonstrable improvement in performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project identified.

q. ✔ Use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

r. ✔ Ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

s. ✔ Administer their QAPI through clear and appropriate administrative arrangements.

t. ✔ Formally evaluate, at least annually, the effectiveness of the QAPI strategy, and make necessary changes.

~~**u.** ___ Other (please describe):~~

VIII. Attachments

Rules and Regulations for the Colorado Public Mental Health System. Attachment C.I.b.

PIHPs' Performance Indicator Results FY '01 and '02. Attachment C.VII.c.

Section D. Cost Effectiveness

This section of the waiver renewal application demonstrates the cost effectiveness of the waiver during the current and future waiver periods, including State fiscal years (FY) 00-01 through FY 04-05. This cost effectiveness analysis demonstrates that services provided under the Colorado Medicaid Mental Health Capitation and Managed Care Program in these fiscal years have been, and are projected to be, less expensive than the cost of providing the same services without the waiver (under a fee-for-service program).

I. Methodology to Demonstrate Cost Effectiveness

The methodology used in this waiver application to demonstrate cost effectiveness is essentially identical to the methodology used in the State's previous waiver request. Specifically, the demonstration of cost effectiveness is based on comparing projections of total expenditures without the waiver (under a fee-for-service reimbursement system) with actual and projected total expenditures for services provided with the waiver. In general, this cost effectiveness analysis is based on per-member per-month (PMPM) costs, using base year fee-for-service (FFS) (or without waiver) costs adjusted to account for changes in the number of eligibles. The cost effectiveness methodology is described in detail below.

With Waiver Months - Previous and Upcoming Waiver Period

The number of member months for the previous waiver period (Year 1 and Year 2) and the upcoming waiver period (Year 3 and Year 4) are provided in Table 1 (Attachment D.1.). The estimated member months are based on actual state eligibility data and program experience in Year 1 and Year 2. Year 1 and Year 2 actual member months were inflated based on the inflation factors provided in the table below. The Colorado Department of Health Care Policy and Financing and the Governor's Office of State Planning and Budgeting provided these factors.

Waiver Year	State Fiscal Year	OAP-A	OAP-B, AB,AND	AFDC-A BC-A	AFDC-C BC-C	Foster Care
3	FY 02-03	0.94%	0.77%	12.54%	12.02%	2.00%
4	FY 03-04	1.01%	0.87%	9.51%	7.00%	1.70%
5	FY 04-05	1.01%	0.87%	9.51%	7.00%	1.70%

Without Waiver Costs - Data and Base Year Calculations

Historical FFS costs by eligibility category by area were gathered for the Base Year. Member Months for each specific category were gathered, and the PMPM rates for each cell were derived (Attachment D.1. Table 2). Table 2 details the expenditures, member months, and PMPM costs for the three pre-capitation years for the entire state and for the uncapitated area for FY 96, by eligibility category.

This data was extracted from the State's claims history file and represents FY 92-93 through FY 95-96 for all pre-waiver covered services. Data in FY 92-93, FY 93-94 and FY 94-95 include all 15 geographic areas. Data in FY 95-96 represents only the remaining FFS areas; areas 1,4, and 7. FY 94-95 is used as the base year for 12 of the 15 areas to determine what costs would have been without capitation, and FY96 is used as the base year for remaining areas.

For the purpose of this waiver, Aid to the Blind, OAP-B and AND were combined, AFDC-Adult and Baby Care Adult were combined, and AFDC-Child and Baby Care Child were combined. OAP-B, Aid to the Blind, and Baby Care were determined too small to practically set rates in those categories by geographic area. Undocumented aliens, OAP-State Only, and Qualified Medicare Beneficiary were excluded from the calculations.

Service costs in the historical FFS payment files and data in the table above include:

- *Inpatient Under 21 Psychiatric Hospitals*
- *State Psychiatric Hospitals including*
  Under 21 Psychiatric Service
  Over 65 Psychiatric Service
- *Rehabilitation Option for Psychiatric Services*
- *General Hospital Inpatient Psychiatric Service*
- *Hospital Outpatient Psychiatric Service*
- *Physician Services and Psychologists*

The following costs are not included:

- *Co-payments*
- *Coinsurance*
- *Third party liability recoveries*

Estimated Without Waiver PMPM Costs – Years 1 – 5

*The base year PMPM rates (or without waiver rates) included in Table 2 (*Attachment D.1.) *were inflated by 4.4 percent per year to establish the projected Without Waiver PMPM Rates for Years 1 – 5 (Attachment D.1. Table 3). The 4.4 percent per year inflation rate represents the inflation rate used in an earlier waiver and represents the average actual increase in FFS costs per eligible for FY 91-92 through FY 94-95.*

Comparison of "Without Waiver" Rates and Waiver Rates

- *The without waiver rates for the current waiver period are then compared with actual and budgeted waiver area-specific and eligibility category-specific rates. These comparisons are summarized in Table 4 (Attachment D.1.).*

- *Using the actual (and projected) Medicaid-eligible member months (Attachment D.1. Table 1) for each area and category, the aggregate costs of both the with and without waiver programs are computed (Attachment D.1. Tables 3 and 4). Please not these tables do not reflect the impact of the adjustments These do not yet include the costs of adjustments discussed below.*

- *The inflation factors presented earlier were applied to the data in Tables 6 and 7 (Attachment D.1.) to yield the aggregate costs of with- and without waiver programs in future years. These costs are summarized in Table 8 (Attachment D.1.).*

- *Adjustments were made to the PMPM costs for the following situations. Each of these adjustments is summarized in Table 9 (Attachment D.1.) and detailed in Tables 10 through 15 (Attachment D.2.).*

    a) *payments made through the MMIS system for gross adjustments;*
    b) *carve-out of certain populations which were covered in the original capitation plan;*
    c) *increase in payments for the Goebel plaintiff class to account for additional Medicaid representation in this class as well as payments for additional services provided;*
    d) *payments to cover increase in payments by the MHASAs for increased state mental health institute rates; and,*
    e) *performance incentive payments.*

Adjustments were made to the with-waiver and without waiver totals for items a-e above (Attachment D.1. Table 9). The nature of each of these adjustments is explained

separately and each accounts either for additional capitation dollars spent for waiver-covered services, or for dollars initially factored into the capitation rates, and later "carved out" of the capitation program. These additional adjustments are done after the PMPM analysis because these costs cannot be attributed to a particular eligibility category. Spreadsheets detailing each adjustment are provided in Tables 10-15 (Attachment D.2.).

II. Detail Regarding Program Adjustments

Gross Adjustments

Undefined Eligibility Category Payments - The effect of certain system changes made over several years results in a loss of a small amount of payment detail in the MMIS system. In these cases, the eligibility category for which a payment was made cannot always be defined. For purposes of this waiver application, these payments are lumped together as Undefined Category payments.

Lookback Settlement – The effect of changing the State fiscal agent from Blue Cross Blue Shield to Consultec in 1998 caused a problem in identifying the exact amount owed by the State to the MHASAs for retroactive eligibility. These payments were ultimately made on a settlement basis, using historical trends to project amounts owed. See Table 10 (Attachment D.2.).

Program Carve Outs

Regional Center Clients – Beginning July 1, 2001, the clients at the State Regional Centers for the Developmentally Disabled were carved out of the capitation program. This was done to more clearly identify who was responsible for mental health care for these individuals, as only partial responsibility was previously given to the MHASAs for their care.

Process: The projected FY 01-02 aggregate capitation payments for the OAP-B, AB, and AND population were calculated by MHASA. The aggregate MHASA payments for this population less the historical (FY 99-00) aggregate costs for this population was calculated. This amount was then targeted for adjustment in the capitated rate for OAP-B, AB, and AND category. This amount was subtracted from the pre-change aggregate amount to yield the FY 01-02 post-change aggregate payments. The projected aggregate payment amount was divided by the projected number of member months (without this population) to yield the new capitation payment rate for the rate category. See Attachment D.2. Table 11.

Not Guilty by Reason of Insanity Client "Carve Out" – Beginning April 1, 2001, the Not Guilty by Reason of Insanity (NGRI) clients at the Colorado State Mental Health Institute at Pueblo (CMHIP) were carved out of the capitation program. This change was made to recognize the high cost of caring for these individuals and the lack of control the MHASAs have over managing these individuals treatment.

Process: The FY 99-00 cost of care for the current NGRI population (as of November 2000) was computed, using CMHIP data. These costs were allocated to each MHASA using county of origin and applying the average length of stay of the 14 NGRI clients. Each MHASA's allocation of the NGRI costs were subtracted from their original RFP rate bid, and a new rate calculated by using the RFP caseload projected estimates for FY 00-01. The same process was repeated for FY 01-02 rates, using RFP caseloads for FY 01-02.

This rate adjustment is continued at a flat rate until the new bid process incurs. Area 9, Colorado Springs, did not incur their allocated portion of the NGRI carve out reduction until the new vendor chosen through the bid process was put into control in October 2001. The delay was due to an appeal process for the bids, which was not settled until that time. See Attachment D.2. Table 12.

Goebel Plaintiff Class Carve Out – Effective July 1, 2001, payments for the plaintiff class of the Goebel lawsuit (affecting the rates of Area 7 only) were carved out of the capitation program. The court dictates the services provided by the MHASA and the MHASA has no ability to modify the service package. Therefore, the State has always required that the MHASA pass through the lump sum payment for these services to the local provider. By carving this lump sum out of the capitation rate entirely, the MHASA is paid exactly the right amount from the State to fund their pass-through to the local provider, and the payment is not subject to variances in the AND population at large.

In FY 01-02 the State received permission from the Center for Medicare and Medicaid Studies (CMS) to increase the funding of the Goebel class in recognition of the increased spectrum of services required and related costs of the court-dictated services. Note that the aggregate PMPM payments paid to Area 7 provider beginning FY02 do not include this significant lump sum payment. See Attachment D.2. Table 13.

<u>Goebel Refinancing</u>

Increase in Medicaid Portion of the Goebel Class – Effective July 1, 2001, the State received permission from CMS to increase Medicaid payments for the Goebel class based on an increase over time in the percentage of the plaintiff class that is Medicaid eligible. A Medicaid penetration rate of 60% is used in allocating the total court-required

Goebel dollars to Medicaid, and a reconciliation process put into place in the MHASA contract amendment to protect against overpayment. See Attachment D.2. Table 13.

State Mental Health Institute - Rate Refinance

Increase in Colorado State Mental Health Institute rates - The institutes identified a significant discrepancy between their costs and the rates paid by Medicaid and other providers. Effective October 1, 2001, with the permission of CMS, rates were increased to all providers to reflect the actual cost of care. Due to this unanticipated rate increase to the MHASAs, which was not identified in the RFP issued by the State in 2000, the MHASAs were held harmless for the effect of the rate increase.

Process: The institutes bill the increased rates to the MHASAs, and MHASAs pay at the higher rate. The MHASA is reimbursed the increase in their payments on the basis of actual hospital utilization. This gross adjustment is paid to the MHASAs on a monthly basis in addition to the regular PMPM payment. See Table 14 (Attachment D.2.).

Performance Incentives

A performance incentive was issued to the MHASAs for the fourth quarter of FY 00-01, based on an estimate of 2 percent of the FY 00-01 program expenditures. At the time, it was anticipated that the program would be ongoing, but State fiscal shortfalls have put this plan on hold. See Table 15 (Attachment D.2.) for distributions.

Process: A contract amendment was put into place to define the basis of the awards. See Attachment D.2. Performance Incentive Contract Amendment.

III. Administrative Costs for Waiver and Renewal Periods

Certain administrative costs associated with the project are not included in the above calculations of base cost effectiveness. These costs are in addition to the State's cost to administer the previous FFS program. Table 16 (Attachment D.3.) provides these costs in detail, including salaries and benefits and travel and operating expenses by State FY. The cost categories are summarized below:

- *Data Collection – The State increased data collection in order to determine the effectiveness of the program. The program has and will continue to utilize one FTE during the five fiscal years this waiver covers.*

- *Quality Assurance – The State increased quality assurance monitoring activities to ensure adequate and effective services were being delivered*

under the waiver program. Three FTE have been allocated to this task for all five years this waiver covers.

- *Fiscal Monitoring – The State increased its staff by one FTE to monitor the payment systems and fiscal operations of the MHASAs. The one FTE is consistently allocated throughout the five years this waiver covers.*

- *Grievance System – The State expanded the grievance system by one FTE to provide recipients with access to the State via an 800 number to quickly resolve complaints and grievances. The one FTE is consistently allocated throughout the five years this waiver covers.*

The aggregate administrative costs associated with the State's waiver program are summarized in the table below:

Actual FY 00-01	Actual FY 01-02	Budgeted FY 02-03	Budgeted FY 03-04	Estimate FY 04-05
$546,811	**$563,898**	**$592,017**	**$607,542**	**$623,533**

IV. Calculation of Net Cost Effectiveness – Years 1 and 2

The following tables summarize the calculation of net cost effectiveness of the waiver program for waiver years 1 and 2, including all of the adjustments discussed under #2 above and the administrative costs discussed under #3 above. See Table 17 (Attachment D.4.) for more detail.

Fiscal Year 2001 (Year 1)

Costs without Waiver	$168,172,203
Costs with Waiver	138,546,365
Gross Savings	29,625,838
Less Administrative Costs	546,811
Net Savings	$29,079,027
Net Percentage Savings	17.29%

Fiscal Year 01-02 (Year 2)

Costs without Waiver	$191,696,617
Costs with Waiver	146,160,074
Gross Savings	45,536,543

Less Administrative Costs	563,898
Net Savings	$44,972,645
Net Percentage Savings	23.46%

V. Calculation of Net Cost Effectiveness – Years 3- 5

The following tables summarize the calculation of net cost effectiveness of the waiver program for waiver years 3 - 5, including all of the adjustments discussed under #2 above the administrative costs discussed under #3 above. See Attachment D.4. Table 17 for more detail.

Fiscal Year 02-03 (Year 3)

Costs without Waiver	$208,793,566
Costs with Waiver	150,600,569
Gross Savings	58,192,997
Administrative Costs	592,017
Net Savings	$57,600,980
Net Percentage Savings	27.59%

Fiscal Year 03-04 (Year 4)

Costs without Waiver	$223,746,115
Costs with Waiver	155,648,423
Gross Savings	68,705,234
Administrative Costs	607,542
Net Savings	$68,097,692
Net Percentage Savings	30.44%

Fiscal Year 04-05 (Year 5)

Costs without Waiver	$239,286,287
Costs with Waiver	162,148,121
Gross Savings	77,138,166
Administrative Costs	623,533
Net Savings	$76,514,63
Net Percentage Savings	31.98%

ASSURANCES: **Assurance** (Please initial or check)

_____ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial Officer:__John Bartholomew_____

Telephone Number:____(303) 866-3200_____

VI. Type of Contract

The response to this question should be the same as in **A.II.e**.

~~**a.**___ Risk-comprehensive (fully-capitated--MCOs, HIOs, or certain PIHPs)~~

b.____✔ Other risk (partially-capitated--PIHP)

~~**c.**___ Non-risk. Please use Section C of the PCCM initial application.~~

~~**d.**___ Other (please explain):~~

VII. Member Months

a. Population in base year data

1.____✔ Base year data is from the same population as to be included in the waiver.

~~2.__ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation which supports the conclusion that the populations are comparable.)~~

VIII. Without Waiver Data Sources and Adjustments

Previous Waiver Period

~~**a.**___ During the last waiver period, the methodology used to calculate cost-effectiveness was different than described in the waiver governing that period. The differences were:~~

~~Please note the date of any methodology change and explain any methodology changes in this preprint. See also Step 5.~~

Upcoming Waiver Period -- For all three subsets of adjustments (Without Waiver Response required, Optional, and With Waiver Cost Adjustments) in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to ~~MCOs~~/PIHPs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment. If this exemption applies to the State, please identify and describe in the Other Block.

~~1.___ We assure HCFA that DSH payments are excluded from base year data.~~

2.✔ We assure HCFA that DSH payments are excluded from adjustments.
~~3.___ Other (please describe):~~

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 47): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.

Basis:

~~1.___ IBNR adjustment was made. Please indicate the number of years used as basis _____.~~
~~i.___ Claims in base year data source are based on date of service.~~
~~ii.___ Claims in base year data source are based on date of payment.~~

2.✔ IBNR adjustment was not necessary (Please explain).

Methodology:

~~1.___ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.~~

2.✔ Other (please describe):

Data for base year calculations were pulled from the claims paid file after the timely filing period had expired.

c. Inflation (Appendix D.III, Line 48): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.

Basis:

1.✔ State historical inflation rates

(a) Please indicate the years on which the rates are based: Inflation base years 3

(b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

Linear regression.

~~2.___ Other (please describe):~~

d. Third Party Liability (TPL) (Appendix D.III, Line 61): This adjustment should be used only if the State will not collect and keep TPL payments for post-pay recoveries. If the ~~MCO~~/PIHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and methodology:

1.✔ No adjustment was necessary

2.✔ Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database.

~~3. State collects TPL on behalf of MCO/PIHP enrollees~~

~~4. The State made this adjustment:~~

~~5. Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs.~~

~~6. Other (please describe):~~

e. FQHC and RHC Cost-Settlement Adjustment (Appendix D.III, Line 46) : This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PIHP to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

~~1. Cost-settlement supplemental payments made to FQHCs/RHCs are included in without waiver costs, but not included in the MCO/PIHP rates, base year UPL costs, or adjustments. The State also accounted for any phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA. If the State pays a percentage of cost-settlement different than outlined in the BBA not to exceed 100 percent, please list the percentage paid _____. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.~~

2.✔ Other (please describe):

MHASAs are required by contract to pay the FQHC's their reasonable costs out of their capitation payments.

f. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 51): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

1. ___ Payments outside of the MMIS were made. These payments include (please describe):
2. ___ Recoupments outside of the MMIS were made. These recoupments include (please describe):
3. ✔ The State had no recoupments/payments outside of the MMIS.

g. Pharmacy Rebate Factor (Appendix D.III, Line 68): Rebates that States receive from drug manufacturers should be deducted from UPL base year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.

Basis and Methodology:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.
2. ✔ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.
3. ___ Other (please describe):

Optional Adjustments

a. Administrative Cost Calculation(Appendix D.III, Line 44): The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PIHP if these members had been enrolled in FFS. Only those costs for which the State is no longer responsible should be recognized. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

Basis:

~~1.___ All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to ___ percent of FFS service costs.~~

~~2.___ The State has chosen not to make adjustment.~~

3.✔ Other (please describe):

The costs are shown by type above in the "cost effectiveness description."

Methodology:

~~1.___ Determine administrative costs on a PMPM basis by adding all FFS administrative costs and dividing by number of total Medicaid FFS members~~

~~2.___ Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell.~~

3.✔ Other (please describe): Described above under administrative costs.

b. Copayment Adjustment (Appendix D.III, Line 45): This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these copayments are included in the UPL if not to be collected in the capitated program.

Basis and Methodology:

~~1.___ Claims data used for UPL development already included copayments and no adjustment was necessary.~~

~~2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program.~~

3.✔ The State has chosen not to make adjustment.

~~4.___ Other (please describe):~~

c. Data Smoothing Calculations for Predictability (Appendix D.III, Line 65): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.

Basis and Methodology

~~1.___ The State made this adjustment (please describe):~~

2.✔ The State has chosen not to make adjustment.

d. Investment Income Factor (Appendix D.III, Line 50): This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of services.

~~1.___ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided.~~

2.✔ The State has chosen not to make adjustment.
~~3.___ Other (please describe):~~

e. PCCM case-management fee deduction (Appendix D.III, Line 52): When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

~~1.___ PCCM claims data were used to create capitated UPLs and management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.~~

2.✔ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.

~~3.___ Other (please describe):~~

f. Pooling for Catastrophic Claims (Appendix D.III, Line 53): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

~~1.___ The high-cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.~~

2.✔ The State has chosen not to make adjustment.

~~3.___ Other (please describe):~~

g. Pricing (Appendix D.III, Line 54): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1.✔ Expected State Medicaid FFS fee schedule increases between the base and rate periods.

~~2.___ The State has chosen not to make FFS price increases in the managed care rates.~~

~~3.___ Changes brought about by legal action (please describe):~~

~~4.___ Changes in legislation (please describe):~~

~~5.___ Other (please describe):~~

h. Programmatic/policy changes (Appendix D.III, Line 55): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, Federal mandates, changes in hospital payment from per diem rates to

Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.

Basis and Methodology:

1.✔ The State made this adjustment (please describe). See section detailing program adjustments.
~~2.___ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.~~

i. Regional Factors applied to Small Populations (Appendix D.III, Line 59): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.

Methodology:

~~1.___ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smooths out wide fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.~~

2.✔ The State has chosen not to make adjustment.
~~3.___ Other (please describe):~~

j. Retrospective Eligibility (Appendix D.III, Line 60): States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs/PIHPs will not incur costs associated with retrospective eligibility because capitated eligibility is prospective. Please note, however, that newborns need not be removed from the base year costs if the State provides retrospective eligibility back to birth for newborns.

Basis and Methodology:

~~1.___ Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-~~

~~eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed.~~

2. ✔ The State has chosen not to make adjustment because it was not necessary given the State's enrollment process.

~~3. ___ Other (please describe):~~

k. Utilization (Appendix D.III, Line 62): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

~~1. ___ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors.~~

2. ✔ The State has chosen not to make adjustment.

~~3. ___ Other (please describe):~~

~~**l.** Other Adjustments including but not limited to guaranteed eligibility and risk-adjustment (Appendix D.III, Line 63). If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, HCFA expects States to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology:~~

With Waiver Cost Adjustments

a. Reinsurance or Stop/Loss Coverage (Appendix D.III, Line 71): Please note whether or not the State will be providing reinsurance or stop/loss coverage. Reinsurance may be provided by States to MCOs/PIHPs when MCOs/PIHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP will be responsible. If the State plans to implement either reinsurance or stop/loss, a description of the methodology used is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The rate of expenses per capita

should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in with waiver costs.

Basis and Methodology:

1. ✔ The State does not provide reinsurance or stop/loss for MCOs/PIHPs, ~~but requires MCOs/PIHP to purchase such coverage privately. No adjustment was necessary.~~
~~2. ___ The State provides reinsurance or stop/loss (please describe):~~

b. Incentive/bonus payments (Appendix D.III, Line 72): This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. The State must document the criteria for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs do not exceed the UPL. The costs associated with any bonus arrangements must be accounted for in Appendix D.V With Waiver costs. Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs/PIHPs do not exceed the UPL:

See section labeled "Performance Incentive Adjustment".

c. Other Adjustments (Please list and describe the basis and methodology):

See #2 in Section D – Cost Effectiveness for a detailed discussion of With Waiver adjustments.

IX. Without Waiver Development

Please refer to data tables at end of this section.

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver.

X. With Waiver Development

a. Please mark and complete the following assurances to HCFA:

1. ✔ The State assures HCFA that the capitated rates will be equal to or less than the UPL based upon the following methodology. Please attach a description of the rate setting methodology and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL.

~~(a)__ Rates are set at a percent of UPL~~
~~(b)__ Negotiation (please describe):~~
~~(c)__ Experience-based (contractor/State's cost experience or encounter data) (please describe):~~
~~(d)__ Adjusted Community Rate (please describe):~~

(e) ✔ Other (please describe): Competitive bid process to select PIHP's in the eight geographic areas, UPL is set at 95% of projected FFS PMPM for each geographic area by eligibility category.

~~2.___ The rates were set in an actuarially sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates.~~

~~3.___ The State will submit all capitated rates to the HCFA RO for prior approval.~~

b. ✔ The State is requesting a 1915(b)(3) waiver in section A.II.g.2 and will be providing non-state plan medical services.

~~1. The State will be spending a portion of its savings above the capitation rates for additional services under the waiver.~~

~~Please state the actual amounts spent on 1915(b)(3) savings which was spent on additional services in the previous waiver period_____. This amount must be built into the State's with waiver costs for Years 1 and 2.~~

~~Please state the PMPM or aggregate amount of 1915(b)(3) savings which will be spent on additional services in the upcoming waiver period_____. This amount must be built into the State's with waiver costs for Years 3 and 4.~~

2. ✔ The State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical services.

Please state the actual amount or percent of the PMPM that was spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please document the actual amount spent on non-State plan medical services.

Please estimate the amount or percent of the PMPMs that will be spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please explain the assumptions that the State used to calculate this amount.

See Table 18 for Year 1 and Year 2 expenditures on non-State plan services. Please note that all with waiver actual and projected cost figures for Years 1 – 5 provided earlier in this waiver renewal application include the actual and projected cost of these non-State plan services.

XI. Attachments

With/Without Waiver Costs (Tables 1-9). Attachment D.1.

Adjustments (Tables 10-15). Attachment D.2.

Performance Incentive Contract Amendment. Attachment D.2.

Administrative Costs (Table 16). Attachment D.3.

Calculation of Waiver Cost Effectiveness (Table 17). Attachment D.4.

Optional Services Cost (Table 18). Attachment D.X.b.2.

Section E. Fraud and Abuse

States can promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the ~~MCOs~~/PIHPs have certain provisions in place.

Previous Waiver Period

a. ___ ~~During the last waiver period, the program's fraud and abuse requirements operated differently than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period [items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint].

In early 2002, Mental Health Services staff reviewed the PIHPs' program integrity systems. The information reviewed by PIHP included the following:

- *Name and title of the person who serves as the Program Integrity Officer;*
- *Procedures for responding to and reporting suspected fraud;*
- *Description of any systems changes and corrective actions taken in response to suspected incidences of fraud, if applicable;*
- *Documentation of the PIHP's efforts to inform providers of policies concerning fraud.*

All eight of the PIHPs had Program Integrity Officers in place and acceptable fraud and abuse policies and procedures. In addition, all of the PIHPs documented adequate efforts to inform their providers of their policies concerning fraud. There have been no actionable findings, therefore no corrective actions have been taken during this waiver period for fraud and abuse.

Upcoming Waiver Period -- Please check all items below which apply, and describe any other measures the State takes. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

I. State Mechanisms

a. ✔ The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the ~~MCO~~/PIHP, by the State's claims processing system).

b. ✔ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c. ✔ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

*The formal plan for preventing fraud and abuse is contained in 10 CCR 2505 10 §8.076-8.076.52. A copy of these rules is contained in Attachment E.I.c.***

d. ✔ The State has a specific process for informing ~~MCOs~~/PIHPs of fraud and abuse requirements under this waiver. If so, please describe.

"The contractor shall have a Program Integrity Officer who shall be responsible for detecting potential incidents of Medicaid fraud and reporting such incidents to the Medicaid Fraud Control Unit of the Colorado Attorney General's Office and the Director of the Managed Care Contracting Division of the Department of Health Care Policy and Financing. The contractor shall:

- *develop procedures for immediately responding to and reporting suspected fraud;*
- *inform providers of Medicaid and contractor policies concerning fraud;*

- *take appropriate enforcement action against providers found by the Attorney General's Office to have committed Medicaid fraud;*

- *take appropriate actions to prevent further offenses through systems changes and corrective actions; and*

- *comply with requirements of the National Practitioner Data Bank and the Colorado State Board of Medicaid Examiners concerning fraud."* [68]

*In addition, the PIHPs will be required to have program integrity compliance plans designed to guard against fraud and abuse and maintain program compliance committees that are accountable to senior management (Final Rule: Medicaid Managed Care; 42 CFR, 438.608 (a) & (b)(2)). Implementation of these requirements will be no later than August 13, 2003.***

~~**c.**___ Other (please describe):~~

II. ~~MCO~~/PIHP Fraud Provisions

~~**a.**___ The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Please describe any required fraud and abuse plan elements.~~

b.✔ The State requires ~~MCOs~~/PIHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations. [69]

[68] *RFP2000 Section III-24. Attachment A.II.e.2.*
[69] *RFP2000 Section III-24. Attachment A.II.e.2.*

III. Attachments

10 CCR 2505 10 §8.076 "Program Integrity." Attachment E.I.c.

Section F. Special Populations

States may wish to refer to the October 1998 HCFA document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

~~**a.** During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:~~

~~**b.** [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint].~~

c. Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

The RFP2000 requires that the PIHP make every reasonable effort to ensure uninterrupted treatment and continued services with a consumer's current provider:

"After contract implementation, the contractor shall offer a contract or a single case agreement to any provider requested specifically by a consumer or family, as long as the provider meets the contractor's credentialing and quality of care criteria. The purpose of this requirement is to offer the greatest degree of choice for consumers and families."[70]

[70] *RFP2000 Section III-28 B. Attachment A.II.e.2.*

If the consumer has a clinical relationship with a provider of mental health services that the consumer wishes to maintain, and the MHASA is unable to make appropriate arrangements, the recipient can request an exemption from the Medicaid Mental Health Capitation and Managed Care Program. Exemption criteria are discussed in detail in Section A.III.b.4.i.

Upcoming Waiver Period -- For items a. through g. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all items which apply to the State.

a. ✔ The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

The State has expanded their definition of special needs populations to all "persons" with special health care needs. The State's definition of special populations, therefore, includes children with special health care needs and adults with special health care needs. Specifically, special needs status is identified through diagnosis code and state eligibility codes. The following aid categories and category codes will be used:

- *45 Aid to Needy Disabled;*
- *46 Aid to Blind;*
- *05 Aid to Needy Disabled/SSI/SSI Med;*
- *06 Aid to Blind/SSI/SSI Med Only; and*
- *25 Aid to Needy Disabled/State Only.*

*Please refer to the list of diagnosis codes that comprise the State's definition of "persons with special health care needs" in Attachment F.I.a..***

b. ✔ There are special populations included in this waiver program. Please list the populations.

All "Special Populations" who are Medicaid eligible are included in the program:

"All persons who are eligible for Medicaid in the contract area, and who are entitled to a full range of mental health benefits, will automatically be enrolled by the State in the contractor's Program." [71]

c. ✔ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies which serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

The RFP2000 requires collaboration and coordination with the following special needs populations, associated agencies, advocates, and family members:

- *Children with special needs due to physical and/ or mental illnesses,*
- *Older adults,*
- *Foster care children,*
- *Homeless individuals,*
- *Individuals with serious and persistent mental illness and/or substance abuse,*
- *Non-elderly adults who are disabled or chronically ill with developmental or physical disability,*
- *And persons whose sight, speech and/or hearing is impaired.* [72]

d. The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

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[71] *RFP2000 Section III-6. Attachment A.II.e.2.*

[72] *RFP2000 outlines the collaboration and coordination requirements in Sections III-65, III-66, III-70 & III-71. Attachment A.II.e.2.*

~~1.____Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)~~

~~2.___ State/local funding sources~~

3.✔ Other (please describe):

The RFP2000 states:

"Coordination of care shall address the consumer's need for integration of mental health and other services. This includes identifying, providing, arranging for, and/or coordinating with other agencies to ensure that the consumer receives the health care and supportive services that will allow the consumer to remain in her/his community and to thrive in that community. Recognizing the importance to consumers of needed medical care, the contractor shall make reasonable efforts to assist individuals to obtain necessary medical treatment. If a consumer is unable to arrange for supportive services necessary to obtain medical care due to her/his mental illness, these supportive services shall be provided by the Care Coordinator or another person who has an existing relationship with the consumer whenever possible." [73]

e.✔ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1.✔ Access to services (please describe):

2.✔ Quality of Care (please describe):

3.✔ Coordination of care (please describe):

4.✔ Enrollee satisfaction (please describe):

~~5.___ Other (please describe):~~

The States' Program Quality Team monitors access, quality, coordination and satisfaction, which includes a sample of special populations. The annual medical chart audit selection

[73] *RFP2000 Section III-65. Attachment A.II.e.2.*

includes consumers in the older adult group, involuntary placements, the physically disabled, deaf and blind. [74]

f. ✔ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.

State contracts require that all facilities meet ADA standards for accessibility.

~~**g.** The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:~~

II. State Requirements for ~~MCOs~~/PIHPs

Previous Waiver Period

~~**a.** During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:~~

~~**b.** [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint].~~

Upcoming Waiver Period For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all the items which apply to the State or ~~MCO~~/PIHP.

[74] *Program Quality Monitoring Protocol FY02 & FY03.*

a. ✔ The State has required care coordination/case management services the ~~MCO~~/PIHP shall provide for individuals with special health care needs. Please describe by population.

The State requires that all mental health services be coordinated by a single "care coordinator":

"The contractor shall be responsible for coordinating the mental health services of each consumer receiving services. The contractor shall assign responsibility for coordinating each consumer's care to a single Care Coordinator. The Care Coordinator may be the consumer's primary therapist, psychiatrist, case manager, or another appropriate person.

The Care Coordinator shall be responsible for service planning, coordination of all mental health services to the consumer, coordination of mental health services with other health and human services, and ensuring that the consumer receives all necessary mental health services. The Care Coordinator shall ensure that different providers who are rendering services to a consumer are aware of the other providers involved in the consumer's treatment and the services being provided by each, as appropriate.

Coordination of care shall address the consumer's need for integration of mental health and other services. This includes identifying, providing, arranging for, and/or coordinating with other agencies to ensure that the consumer receives the health care and supportive services that will allow the consumer to remain in her/his community and to thrive in that community. Recognizing the importance to consumers of needed medical care, the contractor shall make reasonable efforts to assist individuals to obtain necessary medical treatment. If a consumer is unable to arrange for supportive services necessary to obtain medical care due to her/his mental illness, these supportive services shall be provided by the Care Coordinator or another person who has an existing relationship with the consumer whenever possible.

The contractor shall ensure that there is a primary clinical record for each Medicaid consumer who receives mental health services. This record shall include clinical documentation pertaining to the consumer, including documentation of coordination of services to the consumer. The

consumer's Care Coordinator, and all providers rendering mental health services to the consumer, shall be identified in the primary clinical record."[75]

b. ✔ As part of its criteria for contracting with an ~~MCO~~/PIHP, the State assesses the ~~MCO~~/PIHP's skill and experience level in accommodating people with special needs. Please describe by population.

As part of the bid process, the competing PIHPs were required to submit detailed descriptions of their technical skills. The RFP2000 states:

"Offerors must demonstrate that they have the corporate resources and commitment necessary to successfully implement and operate the Medicaid Mental Health Capitation and Managed Care Program in the service areas included in their proposals. Specifically, offerors must demonstrate they have:

- *…the technical skills to implement and operate a managed mental health care program, including but not limited to:*
  - ✓ *experience in providing, through employees and/or subcontractors, a full range of mental health care services and in managing those services;*
  - ✓ *a demonstrated understanding of the principles of Recovery and a commitment to implementing a Recovery Model for adult consumers in the geographic service area of the contract;*
  - ✓ *a demonstrated understanding of the unique needs of children and youth with emotional disorders or mental illness and a commitment to providing comprehensive and integrated services to children, youth and families;*
  - ✓ *the ability to perform the administrative, financial and data processing functions of managed care, including contracting, claims processing, budgeting, accounting and data management;*

[75] *RFP2000 Section III-65. Attachment A.II.e.2.*

- ✓ *the ability to develop a regional network of providers possessing the clinical skills and experience needed to meet the needs of the population enrolled in the Program;*
- ✓ *knowledge of, or an appropriate plan to acquire knowledge of the mental health care needs of the Medicaid population in the geographic service area;*
- ✓ *the capacity to adequately serve the number of Medicaid recipients and the demographic mix of recipients in the service area in a timely manner;*
- ✓ *the ability to provide culturally competent and appropriate services;*
- ✓ *the ability to meet the linguistic needs of consumers, including non-English and limited-English speaking individuals and persons whose sight, speech and/or hearing is impaired;*
- ✓ *the ability to meet the needs of individuals who are physically challenged;*
- ✓ *the ability to meet the mental health needs of individuals who have co-occurring conditions, such as developmental disabilities, substance abuse, and serious medical conditions;*
- ✓ *the ability to coordinate prescription drug benefits with other payers and to assume responsibility for those benefits in the future;*
- ✓ *the ability to develop an adequate number of innovative alternatives to inpatient hospital services;*
- ✓ *the ability to develop and operate a utilization management system, including authorization of clinical services;*

- ✓ *the ability to develop and operate a strong quality improvement system, including the use of outcome measures;*
- ✓ *the ability to collaborate with a variety of health care and human services agencies;*
- ✓ *the ability to collaborate with consumers, family members, and advocates for persons with mental illnesses; and*
- ✓ *the ability to work cooperatively with State and federal regulatory agencies."*[76]

c. ✔ The State requires ~~MCOs~~/PIHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.

The RFP2000 requires contractors to work with providers who have traditionally served consumers who are included in the "special populations" and who are designated as "Essential Community Providers":

"The contractor shall offer a contract to every Essential Community Provider in the geographic service area that provides mental health services. State Medicaid Rules (Section 8.205.11) define Essential Community Provider as "a health care provider that: (a) has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and (b) waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations, pursuant to 26-4-114 (3)(a)(b), C.R.S." State Medicaid Rules (Section 8.206.31) include additional information pertaining to designation as an Essential Community Provider,

[76] *RFP2000 Section III-3. Attachment A.II.e.2.*

and contracts between Managed Care Organizations and Essential Community Providers." [77]

d.___ ~~The State has provisions in contracts with MCOs/PIHPs which allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs.~~ If **not** checked, please explain by population.

The Colorado Medicaid Mental Health Capitation and Managed Care Program does not included PCP services.

e.✔ The State collects or requires ~~MCOs~~/PIHPs to collect population-specific data for special populations. Please describe by population.

*The State requires the PIHPs to collect data on complaints registered by, or on behalf of, the special needs population defined in Section F.I.a. In addition, the State requires each PIHP to submit a network adequacy plan and evaluation annually and has been working with the PIHPs to develop indicators of network adequacy specific to this population. In medical chart audits, the Program Quality Team monitors a sample of charts to assess the quality and appropriateness of care from the overall client population, which includes special needs consumers. ***

f.___ ~~The State requires MCOs/PIHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.~~

1. ~~Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only by population.~~

2. ~~Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations by population.~~

3. ~~Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required~~

[77] *RFP2000 Section III-28-E. Attachment A.II.e.2.*

~~to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance.~~

g. ✔ The State requires ~~MCOs~~/PIHPs to identify individuals with complex or serious medical conditions in the following ways:

1. ✔ An initial and/or ongoing assessment of those conditions

2. ✔ The identification of medical procedures to address and/or monitor the conditions.

3. ✔ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.

~~4. ___ Other (please describe):~~

~~**h.** ___ The State specifies requirements of the MCO/PIHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.~~

III. Attachments

Diagnosis Codes to Identify Persons with Disabilities (Special Needs Population). Attachment F.I.a.

Addendum to Section F – Special Needs Children

Draft Interim Review Criteria for Children with Special Needs from June 4, 1999

This addendum is required if the State mandatorily enrolls children with special needs in any of these five subsets:

1. Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);
2. Eligible under section 1902(e)(3) of the Social Security Act;
3. In foster care or other out-of-home placement;
4. Receiving foster care or adoption assistance; or
5. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as is defined by the State in terms of either program participant or special health care needs.

When addressing these criteria in your written descriptions, please provide the following information by each appropriate subset of children with special needs:

- The State's responsibilities in managed care programs enrolling children with special needs.
- The State's requirements for ~~MCOs~~/PIHPs enrolling children with special health care needs.
- How the State monitors its own actions and that of its contracting ~~MCOs and~~ PIHPs.
- For foster-care children only, the provisions which address the broader, unique issues occurring because of out-of-home, out-of-geographic area placement.

I. State Responsibilities for Managed Care Programs Enrolling Children with Special Needs

a. ✔ Public Process [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has in place a public process for the involvement of relevant parties (e.g., advocates, providers, consumer groups) during the development of the waiver program and has sought their participation in that process. Please describe *(Your description may refer to your waiver responses in Section A.I)*.

Please see Section A.I. "Stakeholder Involvement" for a description of the public input process during the development of the waiver. This process included advocates for special needs children including, but not limited to,

the Federation of Families for Children's Mental Health.

b. ✔ **Definition of Children with Special Needs [Required if the State mandatorily enrolls any of the children with special needs listed above]** The State has a definition of children with special needs ~~that includes at least these five subsets~~:

~~1.___ Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);~~
~~2.___ Eligible under section 1902(e)(3) of the Social Security Act;~~
~~3.___ In foster care or other out-of-home placement;~~
~~4.___ Receiving foster care or adoption assistance; or~~
~~5.___ Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as is defined by the State in terms of either program participant or special health care needs.~~

6. ✔ Other (please describe – *your description may refer to your description in Section F.I.a*).

*Please see Section F.I.a.***

c. ✔ **Identification [Required if the State mandatorily enrolls any of the children with special needs listed above]** The State identifies and/or requires ~~MCOs~~/PIHPs to identify children with special needs. The State collects, or requires ~~MCOs~~/PIHPs to collect specific data on children with special needs. The State explains the processes it has for identifying each of the special needs groups described above. Please describe.

The State requires the PIHPs to identify the special needs population listed above. PIHPs must collect complaint data specific to this population and report it to the State annually. Additionally, the PIHPs must address this population in their provider network adequacy plans and evaluations.

d. ✔ **Enrollment/Disenrollment [Required if the State mandatorily enrolls any of the children with special needs listed above]** The State performs functions in the enrollment/disenrollment process for children with special needs, including:

1. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] Outreach activities to reach potential children with special needs and their families, providers, and other interested parties regarding the managed care program. Please describe *(Your description may refer to your response in Section A.III.b.1)*.

The RPF2000 requires <u>contractors</u> to assure that enrollees have access to providers:

"The contractor must demonstrate that its services are accessible. This shall include:

- *conducting outreach efforts to identify and offer assistance to enrollees who are in significant need of mental health services but are not receiving services."* [78]

If the consumer has a clinical relationship with a provider of mental health services that the consumer wishes to maintain, and the MHASA is unable to make appropriate arrangements, the recipient can request an exemption from the Medicaid Mental Health Capitation and Managed Care Program. Exemption criteria are discussed in detail in Section A.III.b.4.i.

Also, PIHPs are required to provide education about the Program to the public. The RFP2000 states:

"The contractor shall provide public education to ensure that consumers, families, local health and human services agencies and providers, school administrators and teachers, and the general public are knowledgeable about the Mental Health Capitation and Managed Care Program. Public education strategies shall be developed initially and revised as needed with input from consumers, families, and others in the community.

Public education shall address the following:

- *mental illnesses and their symptoms;*
- *the diagnoses that are covered under the Program;*

[78] *RFP2000 Section III-73. Attachment A.II.e.2.*

- *the services that are available through the contractor;*
- *ways to access the service system;*
- *that service decisions are to be made on the basis of need and not on financial considerations;*
- *how to file a complaint with the contractor or the State"* [79]

2. ~~[Required if the State mandatorily enrolls any of the children with special needs listed above] Enrollment selection counselors have information and training to assist special populations and children with special health care needs in selecting appropriate MCO/PIHPs and providers based on their medical needs. Please describe *(Your description may refer to your response in Section A.III.b.4.b).*~~

This item does not apply because Medicaid recipients, including special needs populations, are automatically enrolled in a PIHP based on their county of residence.

3. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] Auto-assignment process assigns children with special health care needs ~~to an MCO/PIHP that includes their current provider or~~ to an ~~MCO~~/PIHP that is capable of serving their particular needs. Please describe *(Your description may refer to your response in Section A.III.b.4.g)*.

All Medicaid eligible persons, including special needs populations, are automatically enrolled by the State in the Program. All PIHPs provide a full range of mental health services.

4. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] A child with special needs can disenroll ~~and re-enroll in another MCO/PIHP~~ for good cause. Please describe *(Your description may refer to your response in Section A.III.b.5.d.iii)*.

[79] *RFP2000 Section III-76. Attachment A.II.e.2.*

Recipients are enrolled in a PIHP based on their county of residence. There is only one PIHP in each of the eight regions in the state. Individual Medicaid recipients may be exempted by the State from the Mental Health Capitation and Managed Care Program, upon their request, under certain circumstances. Consumers granted an exemption are manually enrolled in the Medicaid fee-for-service program by the State's staff. Please see Section A.III.b.4.i for additional details.

5.✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] If an ~~MCO~~/PIHP requests to disenroll or transfer enrollment of an enrollee to another plan, the reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health ~~and substance abuse~~ diagnoses -- against the enrollee. Please describe *(Your description may refer to your response in Section A.III.b.6.a)*.

The PIHP cannot request to disenroll or transfer enrollment of an enrollee to another PIHP due to non-compliant behavior. Disenrollment is the sole responsibility of Colorado Mental Health Services. Please see Section A.III.b.4.i for additional details on the exemption process.

e.✔ Provider Capacity [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring provider capacity for children with special needs, including:

1.✔ [Required if the State mandatorily enrolls any of the children with special needs listed above]The State ensures that the ~~MCOs~~/PIHPs in a geographic area have sufficient experienced providers to serve the enrolled children with special needs (e.g., providers experienced in serving foster care children, children with mental health care needs, children with HIV/AIDS, etc.). Please describe *(Your description may include reference to portions of your response in Section B.III.)*.

Please see Section B.III. b. "Previous Waiver Period" for a description of the PIHPs' network adequacy requirements. In

addition, the State requires each PIHP to submit a network adequacy plan and evaluation annually and has been working with the PIHPs to develop indicators of network adequacy specific to this population.

2. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State monitors experienced providers' capacity. Please describe *(Your description may include reference to portions of your response in Section B.III.)*.

Please see Section B.III. b. "Previous Waiver Period" for a description of the PIHPs' network adequacy requirements. FY'02 and FY'03 Network Adequacy Plans have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). The PIHPs' Network Adequacy Evaluations for FY'02 have also been submitted to CMS. The State reviews both the plans and subsequent evaluations.

f. ✔ **Specialists [Required if the State mandatorily enrolls any of the children with special needs listed above]** The State performs functions in the monitoring specialist capacity, including:

1. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has set capacity standards for specialists. Please describe *(Your description may refer to your response in Section B.III.c)*.

All providers in the Program are mental health specialists. Please see Sections B.III.a.3. and B.III.c. for additional information.

2. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State monitors access to specialists. Please describe. *(Your description may refer to your responses in Section B.IV)*.

All providers in the Program are mental health specialists. Please see Section B.IV.b. for additional details.

3. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has provisions in ~~MCOs'~~/PIHPs' contracts which allow children with special needs ~~who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs or~~ be allowed direct access to specialists for the needed care. Please describe *(Your description may refer to your response in Section F.II.d)*.

All providers in the Program are mental health specialists. PIHPs are required to maintain a provider network that includes as many providers as necessary to provide all consumers, including those with special needs, a choice of providers who are mental health specialists.

4. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires particular specialist types to be included in the ~~MCO~~/PIHP network. If specialist types are not involved in the ~~MCO~~/PIHP network, arrangements are made for enrollees to access these services (for waiver covered services only). Please describe *(Your description may refer to your responses in Section B.III.c)*.

All providers in the Program are mental health specialists. PIHPs are required maintain a provider network that is adequate to serve mental health needs of Medicaid eligible consumers, including those with special needs. Each PIHP is required to submit an annual evaluation of the adequacy of its provider network.

g. ✔ Coordination [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring coordination of care for children with special needs, including:

1. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires an assessment of each child's needs and implementation of a treatment plan based on that assessment. Please describe *(Your description may refer to your response in Section F.II.g)*.

The RFP 2000 states:

"The contractor shall ensure that a clinical service plan is developed for each enrolled individual needing mental health services. This plan shall be developed in partnership with consumers, parents of children and adolescents or others with legal custody, and other family members, professionals and individuals (e.g. friends) when appropriate and when chosen or approved by the consumer.

The State's intent is for consumers, parents or others with legal custody, and other family members and individuals to actively participate, to the greatest extent possible, in establishing measurable goals, identifying strategies to achieve those goals, monitoring progress towards goal achievement, and revising service plans. Service planning should be an interactive and collaborative process, and not one in which consumers and families are simply asked to approve service plans completed by clinical staff. In essence, consumers, parents or others with legal custody, and other family members and individuals should be part of a service planning team. To help facilitate partnerships in service planning, the contractor shall ensure that providers:

- encourage and facilitate the involvement of consumers, families, persons with legal custody, and other individuals chosen or approved by the consumer in all aspects of the service planning process, including the development of initial service plans and any revisions to service plans;
- schedule service planning meetings at times that participants can attend without missing work, whenever possible;
- listen to, consider, and use the experiences and ideas of consumers, families, persons with legal custody and other participants in developing and revising service plans;
- write service plans using language that consumers and families can easily understand;
- offer to provide copies of all initial and revised service plans to those individuals who participated in developing or revising the plans;
- document the involvement of participants, as well as reasons for non-involvement of appropriate key individuals." [80]

[80] *RFP2000 Section III-32. Attachment A.II.e.2.*

2. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has required the ~~MCOs~~/PIHPs to provide case management services to children with special needs. Please describe *(Your description may refer to your response in Section F.II.a)*.

Case management is a required service in the Medicaid Mental Health Capitation Program. As such, it must be provided to any recipient, including special needs children. The following excerpts from the RFP2000 describe the case management programs/services:

"Case Management -- Activities that are community-based and are delivered in the consumer's environment, including:

- *service planning;*
- *outreach;*
- *referral;*
- *supportive interventions;*
- *crisis management;*
- *linkage;*
- *service coordination and continuity of care;*
- *monitoring/follow-up; and*
- *advocacy."*

And

"…Intensive Case Management -- Community-based services averaging more than one hour per week, provided to children with serious emotional disturbances and adults with serious mental illness who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services may include, but are not limited to mentoring." [81]

3. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has developed and implemented a process to collaborate and coordinate with agencies and advocates which serve special needs children and their

[81] *RFP2000 Section III-36. Attachment A.II.e.2.*

families. Please describe *(Your description may refer to your response in Sections A.I, A.III.b, C.VII.a.3, and F.I.c)*.

Please see Sections A.I "Stakeholder Involvement" and F.I.c.

4. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has a process for coordination with other systems of care (for example, Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds) or State/local funding sources. Please describe *(Your description may refer to your response in Section F.I.d)*.

Please see Section F.I.d.

5. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires the ~~MCO~~/PIHP to coordinate health care services for special needs children with: providers of mental health, substance abuse, local health department, transportation, home and community based waiver, developmental disabilities, and Title V services. Please describe *(Your description may refer to your response in Section B.V and Section B.VI)*.

Please see Section B.VI.b "Upcoming Waiver Period".

h. ✔ **Quality of Care Monitoring [Required if the State mandatorily enrolls any of the children with special needs listed above]** The State performs functions in the quality of care monitoring for children with special needs, including:

The State will monitor complaints specific to the special needs population listed above. PIHPs report complaints annually and will report complaints related to this population separately beginning in FY '03. Complaints specific to this population received directly by Mental Health Services will be identified and reported and tracked separately. Trends will be identified and corrective actions implemented as appropriate.

1. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has some specific

performance measures for children with special needs (for example, CAHPS for children with special needs, HEDIS measures stratified by special needs children, etc.). Please describe *(Your description may refer to your response in Section C.VII.b and Section F.I.g)*.

In medical chart audits, the Program Quality Team monitors a sample of charts from the overall client population, which includes special needs populations. When the results of the audit fall below 80 percent, corrective actions are required. Corrective actions are reviewed and approved by the State. The State follows up on corrective action plans by monitoring their completion and assessing their effectiveness in subsequent site reviews.

2. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has specific performance improvement projects that address issues for children with special health care needs. Please describe *(Your description may refer to your response in Section C.VII.d and Section F.I.g).*

All children in the program have special needs. The PIHPs have quality improvement programs that address issues with special needs populations.

i. ✔ **BBA Safeguards [Required if the State mandatorily enrolls children with special needs listed above]** To the extent appropriate, the State has adequately addressed Balanced Budget Act (BBA) guidance that HCFA has issued to date. Please describe.

The State will comply with all applicable rules and regulations, specifically those related to coordination and continuity of care in Section 438.208. State staff attended the APSHA conference, "Moving forward with Medicaid Managed Care: Implementing the BBA Regulations" in Baltimore, MD in August, 2002, as well as training presented by the Denver Regional Office of the Centers for Medicare and Medicaid Services in October. The State has been meeting regularly with Denver Regional Office staff to discuss the new rule in depth. Also, the State has formed a workgroup consisting of representatives of the PIHPs and State staff to implement the requirements of the new regulations.

j. ✔ **Payment Methodology [Required if the State mandatorily enrolls any**

of the children with special needs listed above] The State develops a payment methodology that accounts for special needs populations enrolled in capitated managed care. Please describe *(Your description may refer to your response in Section D.III.I)*.

Historical costs under fee for service for special needs populations are built in to the rates paid to the PIHPs.

k. ✔ **Plan Monitoring [Required if the State mandatorily enrolls any of the children with special needs listed above]** The State performs functions in the monitoring of plans for children with special needs, including:

1. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has in place a process for monitoring children with special needs enrolled in ~~MCOs~~/PIHPs for access to services, quality of care, coordination of care, and enrollee satisfaction. Please describe *(Your description may refer to your response in Section F.I.e)*.

In medical chart audits, the Program Quality Team monitors a sample of charts from the overall client population, which includes special needs children. When the results of the audit fall below 80 percent, corrective actions are required. Corrective actions are reviewed and approved by the State. The State follows up on corrective action plans by monitoring their completion and assessing their effectiveness in subsequent site reviews.

The State will monitor complaints specific to this special needs population. The complaint categories that have been developed by the State in collaboration with the PIHPs are sufficiently detailed to allow the identification of access, quality, and coordination of care issues. Complaint data will be monitored and trends will be identified. Corrective actions will be implemented as appropriate.

In addition, the State is working with the PIHPs to develop indicators specific to this population for inclusion in the PIHPs' provider network adequacy plans and evaluations.

Enrollee satisfaction is gauged by the Mental Health Statistics Improvement Program (MHSIP) consumer satisfaction survey that Mental Health Services administers annually. In addition, the PIHPs

use a variety of satisfaction instruments to supplement the MHSIP.

2. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has standards or efforts in place regarding ~~MCOs'~~/PIHPs' compliance with ADA access requirements for enrollees with physical disabilities. Please describe *(Your description may refer to your response in Section F.I.f)*.

State contracts require that all facilities meet ADA standards for accessibility.

3. ✔ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State defines medical necessity for ~~MCOs~~/PIHPs and the State monitors the ~~MCOs~~/PIHPs to assure that it is applied by the ~~MCOs~~/PIHPs in their service authorizations. Please describe *(Your description may refer to your response in Section F.II.f)*.

The RFP2000 defines medical necessity as follows:

"A. A covered service shall be deemed medically or clinically necessary if, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care, the service:

1. is reasonably necessary for the diagnosis or treatment of a covered mental health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder; and

2. is furnished in the most appropriate and least restrictive setting where services can be safely provided; and

3. cannot be omitted without adversely affecting the consumer's mental and/or physical health or the quality of care rendered;" [82]

[82] *RFP2000 Section III-35. Attachment A.II.e.2.*

Section G. Complaints, Grievances, and Fair Hearings

~~MCOs~~/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

States are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in Subpart E.

I. Definitions:

Previous Waiver Period

~~**a.**___ During the last waiver period, complaints and grievances were defined differently than described in the waiver governing that period. The differences were:~~

Upcoming Waiver Period -- Please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a.✔ Please provide definitions used by the State for complaint, grievance, or appeal.

The State defines complaint and grievance in two documents; The Medicaid Staff Manual Volume 8.209.11 [83] and in a Department of

[83] *10 CCR 2505 10 §8.209.11. Attachment G.I.a.*

Insurance (DOI) Regulation 4-2-17 [84]. Both apply to the contractors' complaint and grievance procedures.

"Complaint shall mean an oral or written expression of dissatisfaction for any reason by a Medicaid MCO client or his/her Designated Client Representative to an MCO or the Department." [85]

Complaint (also) means a written communication primarily expressing a grievance. [86]

Grievance means a circumstance regarded as a cause for protest, including the protest of an adverse determination. [87]

Adverse determination means a determination by a health carrier or its designee that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or coverage for the requested service is therefore denied, reduced, or terminated" [88]

~~b. Please describe any special processes that the State has for persons with special needs.~~

II. State Requirements and State Monitoring Activities

Previous Waiver Period

~~a.~~ ~~During the last waiver period, the grievance standards or State monitoring were different than described in the waiver governing that period. The differences were:~~

b. ✔ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect

[84] *DOI Regulation 4-2-17. Attachment A.III.d.2.*
[85] *10 CCR 2505 10 §8.209.11 F. Attachment G.I.a.*
[86] *DOI Regulation 4-2-17.E. Attachment A.III.d.2.*
[87] *DOI Regulation 4-2-17.I. Attachment A.III.d.2.*
[88] *DOI Regulation 4-2-17.A. Attachment A.III.d.2.*

to complaints, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint]. Also, please provide summary information on the types of complaints, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Improvement Strategy.

FY '01 and FY '02 complaint and grievance summary reports have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). An issue identified in the development of these reports was complaint categories that were poorly defined. This resulted in data that was inconsistently categorized by the PIHPs. An extensive review of the categories and definitions in a collaborative effort with PIHP consumer representatives, PIHP quality improvement program personnel, and State staff resulted in a new set of complaint categories and definitions that was implemented July 1, 2002. A listing of these categories and definitions has been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).

The State has specifically addressed access and quality of care concerns as part of its' Capitation monitoring. During the previous waiver period, access to emergency, urgent, and routine care for each of the eight PIHPs was monitored against contract standards. The results of these monitoring efforts were submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).

PIHP access issues have also been addressed with the State's requirement that the PIHPs submit Provider Network Adequacy Plans and Evaluations. The FY '02 Plan and Evaluation have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). A Network Adequacy Workgroup has been formed with the intent of standardizing measures across PIHPs as well as researching standards and developing baseline studies. The State will use the results of the PIHPs evaluations as the basis to certify to CMS the adequacy of provider networks statewide in the upcoming waiver period.

c. Please mark any of the following that apply:

1. ✔ A*n 800 number* ~~hotline~~ was maintained which handles any type of inquiry, complaint, or problem.

2. ✔ Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period. [89]

3. ✔ There is consumer involvement in the grievance process. Please describe.

   Complaints and grievances are initiated by a consumer either verbally or in writing. The complaint process requires the contractor and the State to reply in writing to the consumer at designated times during the complaint process. Consumers may represent themselves, assign a designee or use the Independent Ombudsprogram.

   The Ombudsprogram operates independently from the contractors and the State:

   "The Mental Health Ombudsprogram of Colorado is an independent program that provides advocacy, assistance and education for consumers and families enrolled in the Mental Health Capitation and Managed Care Program. The Ombudsprogram is a non-profit 501(c)(3) organization, governed by a Board of Directors. At least two-thirds of the members of the Board are consumers or family members of consumers in the public mental health system." [90]

   The development of the complaint process continued during the previous waiver period. Complaint categories and definitions were revised and refined through the efforts of State staff, PIHPs' Quality Improvement Program staff, and the Advocates Forum, a public forum consisting primarily of

[89] *FY '01 and FY '02 complaint and grievance summary reports have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS).*

[90] *RFP2000 Section III-85. Attachment A.II.e.2.*

consumer representatives from the PIHPs. The revised categories and definitions were implemented July 1, 2002.

Upcoming Waiver Period -- For items a. and b. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any State requirements and State monitoring activities in effect for ~~MCO~~/PIHP grievance processes.

a. Required Complaints, Grievances, and Fair Hearings Elements:

1. ✔ The State requires ~~MCO~~/PIHPs to have a written internal grievance procedure, providing for prompt resolution of issues and assuring participation of individuals in authority.

2. ✔ The ~~MCO~~/PIHP grievance process is approved by the State prior to its implementation.

3. ✔ An ~~MCO~~/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. Please explain how, under what circumstances (i.e., direct access or exhaustion), and when an enrollee can access the State Fair Hearing process_____

"The client or his/her DCR may request, in writing, an ALJ Appeal of an MCO's adverse service determination at any point in the complaint and appeal process." [91] **

4. ✔ Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.

5. ✔ The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of

[91] *10 CCR 2505 10 §8.209.31. Attachment G.I.a.*

treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated.

6. ✔ Enrollees are informed about their complaint, grievance, and fair hearing rights at the time of ~~MCO~~/PIHP enrollment and/or on a periodic basis thereafter. Please specify how and through what means enrollees are informed._____

Enrollees are informed of their rights to complain at the time of enrollment and on a periodic basis thereafter based on the requirements in RFP2000:

"Consumer Notification About The Program

The contractor shall provide written notification about the Mental Health Capitation and Managed Care Program to all Medicaid recipients enrolled in the Program. Written notification shall include information on the following:

…(the right to) file a complaint;

…the contractor shall disseminate written materials as follows:

- *Newly Enrolled Consumers -- At least monthly, the contractor shall identify all individuals who are newly enrolled in the Program or who have been re-enrolled after an absence of one year or longer, and send written notification about the Program to the identified enrollees. New enrollees may be identified by reviewing enrollment files, or through another method, such as through information provided by county departments of social services. The contractor shall maintain a record of all enrollees who are sent materials each month.*

- *County Eligibility Supervisors -- At the start of the contract, the contractor shall provide a supply of written Program materials to each county department of social services in the geographic service area of the contract. The contractor shall identify the appropriate Medicaid eligibility supervisor(s) in each county department, and provide written materials directly to those individuals. In counties where eligibility for*

adults and children/adolescents are administered separately, the contractor shall identify the supervisors for each population and provide written materials directly to those individuals. The contractor shall request in writing that county eligibility staff provide written materials about the Program to all applicants and/or newly eligible Medicaid recipients at the time county staff provide other written materials about the Colorado Medicaid Program. At least every six (6) months, the contractor shall contact county eligibility supervisors to see if county staff need additional copies of written materials. The contractor shall keep a record of the county staff who receive written program materials, the number of copies provided to county staff and the dates those copies were provided, and the dates and results of the six month inquiries.

- *Federal Social Security Offices -- At the start of the contract, the contractor shall provide a supply of written Program materials to each federal Social Security Office in the geographic service area of the contract. The contractor shall identify the appropriate eligibility supervisor(s) in each Social Security Office, and provide written materials directly to those individuals. In offices where eligibility for adults and children/adolescents are administered separately, the contractor shall identify the supervisors for each population and provide written materials directly to those individuals. The contractor shall request that federal eligibility staff provide written materials about the Program to all applicants and/or persons newly eligible for Supplemental Security Income (SSI) benefits at the time staff provide other written materials about benefits. At least every six (6) months, the contractor shall contact eligibility supervisors to see if staff need additional copies of written materials. The contractor shall keep a record of the Social Security staff who receive written program materials, the number of copies provided to staff and the dates those copies were provided, and the dates and results of the six month inquiries."* [92]

"Member Handbook

[92] *RFP2000 Section III-77. Attachment A.II.e.2.*

In addition to the general Program information provided to all enrollees as described in the previous section of this Statement of Work, the contractor shall provide a Member Handbook to all enrollees who receive mental health services, and to all enrollees and other persons who seek services on behalf of an enrollee. The Member Handbook shall include:

…all of the information included in the written materials sent to enrollees and described in Section III-77, Consumer Notification About The Program, of this RFP…

…procedures for filing a complaint, and a complaint form..."[93]

"Complaint Process

"…In addition to the complaint process that will be defined in State Rules, the following provisions of the contract shall apply:

…written complaint procedures shall be given to and discussed with the consumer and/or family each time a service plan is initially developed…" [94]

b. Optional Complaints, Grievances, and Fair Hearings Elements:

1. ✔ The internal grievance procedure required by the State is characterized by the following (please check any of the following optional procedures that apply to the State's required grievance procedure):

~~(a) The MCO/PIHP governing body approves the grievance procedure and is responsible for the effective operation of the grievance process.~~

(b) ✔ The governing body or its delegated grievance committee reviews and resolves complaints and

[93] *RFP2000 Section III-77. Attachment A.II.e.2.*
[94] *RFP2000 Section III-81. Attachment A.II.e.2.*

grievances. ~~If the State has any committee composition requirements please list~~_____

(c)✔Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

(d)✔Specifies a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing. Specify the time frame _____

"The client or his/her DCR may request, in writing, an ALJ Appeal of an MCO's adverse service determination at any point in the complaint and appeal process." [95]**

(e)✔Includes time frames for resolution of grievances for ~~MCO~~/PIHP grievances. Specify the time frame set by the State _____

"The client or DCR shall contact the MCO to file a complaint about an adverse event.

1. The MCO shall perform a review within fifteen (15) working days of receipt of the client's or DCR's complaint, unless such time is shortened by the Department. (See the definition at 8.209.11,G concerning the appropriate departmental unit.)

2. The MCO shall provide the client/DCR with written notification of the MCO's proposed resolution concerning the client's complaint within two (2) working days of the decision.

[95] *10 CCR 2505 10 §8.209 .31. Attachment G.I.a.*

If the client or DCR is still dissatisfied with the MCO's decision, the client or DCR may file an oral or written request for review of the MCO's proposed resolution with the appropriate plan manager or consumer representative within the Department. (See the definition of "Department" at 8.209.11,G. With respect to complaints involving MHASAs, the appropriate contact person is the Consumer Representative of Mental Health Services.) The departmental plan manager or consumer representative will investigate and issue a determination in writing to the MCO and client/DCR within fifteen (15) working days of the request.

The client or his/her DCR may request an ALJ Appeal in writing if he/she is still unsatisfied with the Department's decision concerning the client's complaint." [96] ***

(f)✔ Establishes and maintains an expedited grievance review process for the following reasons:_____ Specify the time frame set by the State for this process____

"Expedited Review: Clients or their DCRs may request an expedited review of an Adverse Service Determination when the time frame for the standard review procedures [D (1) - (3) below] would 1) seriously jeopardize the life or health of the client, 2) seriously jeopardize the client's ability to regain maximum function, or 3) for persons with a Disability, create an imminent and substantial limitation of their existing ability to live independently. Expedited review shall follow DOI Regulation 4-2-17, § 8 II (A) – (F) and (H). If the Adverse Service Determination is upheld by the MCO, and the MCO issues a

[96] *10 CCR 2505 10 §8.209 B., C., and D. Attachment G.I.a.*

subsequent adverse service notice, the client may file a request for a second level review (D) (3) below." [97] **

(g) ✔ Permits enrollees to appear before ~~MCO~~/PIHP personnel responsible for resolving the grievance.

~~(h) Provides that, if the grievance decision is adverse to the enrollee, the grievance decision and any supporting documentation is forwarded to the State within a time frame specified by the State. Specify the time frame____.~~

(i) ✔ The ~~MCO~~/PIHP acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for ~~MCOs~~/PIHPs to acknowledge complaints and grievances, please specify:

(j) ✔ Gives enrollees assistance completing forms or other assistance necessary in filing complaints or grievances (or as complaints and grievances are being resolved).

(k) ✔ Conducts grievance resolution/hearings using impartial individuals not involved in previous levels of decision making.

(l) ✔ If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a physician with appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease.

[97] *10 CCR 2505 10 §8.209.31 D. Attachment G.I.a.*

(m)✔ Bases the ~~MCO~~/PIHP's decision on the record of the case.

(n)✔ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

~~(o)__ Upon request, provides enrollees and potential enrollees with aggregate information regarding the nature of enrollee complaints and grievances and their resolution.~~

(p)✔ Sets time frames for the ~~MCO~~/PIHP to authorize or provide a service if decision is overturned or reversed through the grievance or fair hearing process. Specify the time frame____

See Section G.II.b.1.e above for time frames.

(q)✔ Informs the enrollee of any applicable mechanism for resolving the issue external to the ~~MCOs~~/PIHPs own processes.

(r)✔ Determines whether the issue is to be resolved through the grievance process, the process for making initial determinations on coverage and payment, or the process for resolution of disputed initial determinations.

~~(s)__ Other (please explain):~~

2.✔ ~~MCOs~~/PIHPs maintain a log of all complaints and grievances and their resolution.

3.✔ ~~MCOs~~/PIHPs send the State a summary of complaints and grievances on at least an annual basis.

4. ✔ The State requires ~~MCOs~~/PIHPs to maintain, aggregate, and analyze information on the nature of issues raised by enrollees and on their resolution.

~~5. The State requires MCOs/PIHPs to conduct in-depth reviews of providers or services identified through summary reports as having undesirable trends in complaints and grievances.~~

6. ✔ The State *supports an independent* ~~and/or MCO/PIHP have~~ ombudprograms to assist enrollees in the complaint, grievance, and fair hearing process.

~~7. Other (please specify):~~

III. Attachments

10 CCR 2505 10 §8.209 "Medicaid Managed Care Complaint and Appeals Process." Attachment G.I.a.

Section H. Enrollee Information and Rights

This section describes the process for informing enrollees and potential enrollees receive about the waiver program, and protecting their rights once enrolled. The information in this section (e.g., enrollee handbooks, enrollment information, PCP choice materials) is considered to be marketing material because it is sent directly to enrollees. However, the traditional marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.III.a).

I. Enrollee Information - Understandable to Enrollees

Previous Waiver Period

~~**a.**___ During the last waiver period, the requirements for understandable enrollee information operated differently than described in the waiver governing that period. The differences were:~~

b. [Required] Please provide copies of the brochure and informational materials explaining the program and how to enroll.

Member handbooks and enrollment letters for each of the eight PIHPs have been submitted to the Denver Regional Office of the Centers for Medicare and Medicaid Services (CMS). An example of the latest State notification document has also been submitted.

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items which apply to the State or MCO/PIHP. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a. ✔ [Required] The State will ensure that enrollee materials provided to enrollees by the State, ~~the enrollment broker~~, and the ~~MCO~~/PIHP are clear and easily understandable.

b. ✔ Enrollee materials will be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

*Currently enrollee materials are translated into English and Spanish. The 1990 Census data, the latest available as of this writing, indicated that 96.2 percent of the State's population over the age of five spoke one or the other (or both) of these languages.[98] The State will establish a methodology for identifying any additional prevalent non-English languages spoken by enrollees throughout the State and will make available written information in each identified prevalent language.***

The State has chosen these languages because (check any that apply):

1. ✔ The languages comprise all prevalent languages in the ~~MCO~~/PIHP service area.
2. ~~The languages comprise all languages in the MCO/PIHP service area spoken by approximately ____ percent or more of the population.~~
3. ~~Other (please explain):~~

c. ✔ Program information is available and understandable to non-English speaking enrollees whose language needs are not met through the provision of translated material described above. Please describe.

The RFP2000 requires the contractor to:

"…make arrangements to accommodate non-English and limited-English speaking consumers and families during all key processes, such as at the time of initial contact, during the intake process, when providing emergency services, when handling complaints, and at administrative hearings…

…establish linkages and contracts with community advocates and agencies that assist non-English and limited-English speaking individuals and/or that provide other culturally appropriate and competent services. These linkages should include methods for outreach and referral…

[98] *1990 Census, Table 4. Languages Spoken at Home by Persons 5 Years and Over*

…provide written information about available mental health programs and services and how to access services, in the languages spoken by consumers…" [99]

d. ✔ [Required] Translation services are available to all enrollees, regardless of languages.

e. ✔ Every new enrollee will have access to a toll-free number to call for questions. Please note if the State requires TTY/TDD for those with hearing/speech impairments:

The RFP2000 requires the contractor to provide:

"…equipment and training to intake and emergency staff and in residential facilities, such as the use of Telecommunication Devices for the Deaf (TDDs), the Colorado Relay Service, 24 hour access to interpreter services for crises, television decoders, and visible (flashing) fire alarms in buildings and residential facilities that may be used by deaf or hard-of-hearing consumers…" [100]

f. ✔ The State requires ~~MCO~~/PIHP enrollee information materials to be translated into alternative formats for those with visual impairments.

The RFP2000 requires:

"All consumer notification materials must be made available in alternative formats for enrollees with visual impairments, including but not limited to Braille, large print, or audio tapes." [101]

II. Enrollee Information - Content

Previous Waiver Period

~~**a.** During the last waiver period, the enrollee information requirements operated differently than described in the waiver governing that period. The differences were:~~

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[99] *RFP2000 Section III-58. Attachment A.II.e.2.*
[100] *RFP2000 Section III-58. Attachment A.II.e.2.*
[101] *RFP2000 Section III-77. Attachment A.II.e.2.*

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a. Information provided by the State and/or its Enrollment Broker. The State and/or its enrollment broker provides the following information to enrollees and potential enrollees.

~~1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities~~

2.✔ An initial notification letter

3.✔ Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

~~4.___ A form for enrollment in the waiver program and selection of a plan~~

~~5.___ A list of plans serving the enrollee's geographical area~~

~~6.___ Comparative information about plans~~

~~7.___ Information on how to obtain counseling on choice of MCOs/PIHPs~~

8.✔ Detailed provider network listings

*Recipients seeking/receiving services will receive information on the non-English languages spoken by the PIHP's current contracted providers as well as identification of providers who are not accepting new patients.***

9. ✔ A new Medicaid card which includes the plan's name and telephone number ~~or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);~~

~~10. __ A health risk assessment form to identify conditions requiring immediate attention.~~

11. ✔ Information concerning the availability of special services, expertise, and experience offered by ~~MCO~~/PIHPs and providers

12. ✔ [Required] Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

~~13. __ [Required for MCOs with lock-in periods] Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b.5)~~

~~14. __ [Required for MCOs] Information on how to obtain services not covered by the MCO/PIHP but covered under the State plan.~~

~~15. __ [Required for MCOs] For enrollees in lock-in period, notification 60 days prior to end of enrollment period of right to change MCOs/PIHPs (See A.III.b.5)~~

~~16. __ Other items (please explain):~~

b. Information provided by the ~~MCO~~/PIHP The State requires the ~~MCO~~/PIHP to provide, written information on the following items to enrollees and potential enrollees. Unless otherwise noted, required items must be provided upon actual enrollment into the ~~MCO~~/PIHP (the BBA requires some information be provided only upon request). Please check all that apply.

1. ✔ ~~[MCOs required to provide upon request]~~ Enrollee rights.

All enrollees receive written information on enrollee rights. The RFP2000 states:

"Written notification shall include information on the following:

- *consumer rights, including the right to:*
  - ✓ *be treated with dignity and respect;*
  - ✓ *participate in service planning;*
  - ✓ *receive written information on available services and network providers;*
  - ✓ *choose a provider from the provider network;*
  - ✓ *request that a specific provider be considered for inclusion in the network;*
  - ✓ *receive a second opinion;*
  - ✓ *confidentiality;*
  - ✓ *refuse treatment, except as provided by law;*
  - ✓ *receive copies of clinical records and service plans;*
  - ✓ *have an independent advocate;*
  - ✓ *file a complaint;*
  - ✓ *available and accessible covered services when medically necessary, including availability of appropriate care 24 hours a day, 7 days a week for urgent and emergent conditions;*
  - ✓ *receive culturally appropriate and competent services from participating providers;*

- ✓ *interpreter services for consumers with communication disabilities or for non-English speaking consumers when such an interpreter is necessary in order to render effective communication in connection with the provision of covered services;*

- ✓ *receive from the consumer's provider, in terms that the consumer understands, an explanation of her/his complete condition, recommended treatment, risks of the treatment, expected results and reasonable alternatives. If the consumer is not capable of understanding the information, the explanation shall be provided to the consumer's biological, adoptive or foster parent, guardian or designated representative, and documented in the consumer's clinical record;*

- ✓ *prompt notification of termination or changes in services or providers;*

- ✓ *express an opinion about the contractor's services to regulatory agencies, legislative bodies, or the media without the contractor causing any adverse effects upon the provision of covered services; and*

- ✓ *any other rights guaranteed by statute or regulation."* [102]

2. ✔ ~~[MCOs required to provide upon request]~~ Enrollee responsibilities.

   Enrollees receive written notification that they are responsible for accessing all non-emergency mental health services through their PIHP and are given specific information on how to do so.

3. ✔ ~~[MCOs required to provide upon request]~~ Names, locations, qualifications and availability of network providers, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among network providers.

[102] *RFP2000 Section III-77. Attachment A.II.e.2.*

"In addition to the general Program information provided to all enrollees as described in the previous section of this Statement of Work, the contractor shall provide a Member Handbook to all enrollees who receive mental health services, and to all enrollees and other persons who seek services on behalf of an enrollee."

And

"Along with the Member Handbook, the contractor shall provide a listing of all providers in the network, including each provider's clinical specialty, organizational affiliation (e.g. CMHC, independent practitioner, etc.), business address and phone number, and languages spoken."

"The Member Handbook and provider listings must be made available in alternative formats for enrollees with visual impairments, including but not limited to Braille, large print, or audio tapes. For enrollees who cannot read, these materials must be available on audio tapes."

"The Member Handbook shall be written at a level that can be easily read and understood by enrolled consumers, and must be approved by the State prior to distribution."

"The Member Handbook shall be updated and distributed to all consumers receiving services at least annually." [103]

4. ✔ ~~[MCOs required to provide upon request]~~ Amount, duration and scope of all benefits (included and excluded).

The Member Handbook, which is provided to all enrollees who seek/receive mental health services, contains a description of benefits that is written in non-technical terms of each specific service available through the program.

~~5. [MCOs required to provide upon request] Physician incentive program, including (1) if the MCO has a PIP that covers referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of survey results, if a survey is required.~~

[103] *RFP2000 Section III-78. Attachment A.II.e.2.*

6. ~~[Required for MCOs] The MCO enrollee materials (either through the enrollee handbook, semi-annual or annual open enrollment materials, or by some other means) annually disclose to enrollees their right to adequate and timely information related to physician incentives.~~

7. ✔ [~~MCOs and~~ PIHPs required to provide upon request *and* upon enrollment] Information explaining the complaints and grievance procedures for resolving enrollee issues, including issues relating to authorization of, coverage of, or payment for services.

In addition to providing written notification about rights, PIHPs are required to provide education about the Program, including the complaints system, to the public. The RFP2000 states:

"The contractor shall provide public education to ensure that consumers, families, local health and human services agencies and providers, school administrators and teachers, and the general public are knowledgeable about the Mental Health Capitation and Managed Care Program. Public education strategies shall be developed initially and revised as needed with input from consumers, families, and others in the community.

Public education shall address the following:

- *mental illnesses and their symptoms;*
- *the diagnoses that are covered under the Program;*
- *the services that are available through the contractor;*
- *ways to access the service system;*
- *that service decisions are to be made on the basis of need and not on financial considerations;*
- *how to file a complaint with the contractor or the State"* [104]

[104] *RFP2000 Section III-76. Attachment A.II.e.2.*

8. ✔ ~~[Required for MCOs]~~ Procedures for obtaining services, including authorization requirements.

In the Mental Health Capitation and Managed Care Program, authorizations are obtained by the providers, not recipients. The PIHPs' Provider Manuals are required to contain authorization requirements.

Prior authorization is not required for emergency services. The RFP2000 states:

"The contractor shall provide written notification about the Mental Health Capitation and Managed Care Program to all Medicaid recipients enrolled in the Program. Written notification shall include information on the following:

- *right to obtain emergency services from any qualified provider, including out-of-network providers, without the prior approval of the contractor;"* [105]

9. ✔ ~~[Required for MCOs]~~ After-hours and emergency coverage. The State ensures enrollee access to emergency services by requiring the ~~MCO~~ *PIHP* to provide the following information to all enrollees [note: ~~these items are required of MCOs only; however,~~ please fill in if applicable for PIHPs]:

The RFP2000 states:

"The contractor shall provide written notification about the Mental Health Capitation and Managed Care Program to all Medicaid recipients enrolled in the Program. Written notification shall include information on the following:

- *right to obtain emergency services from any qualified provider, including out-of-network providers, without the prior approval of the contractor"* [106]

[105] *RFP2000 Section III-77. Attachment A.II.e.2.*
[106] *RFP2000 Section III-77. Attachment A.II.e.2.*

i.✔ the right to use participating and non-participating providers

~~ii.___ definition of emergency services~~

~~iii.__ the prudent layperson definition of emergency medical condition~~

~~iv.__ the prohibition on retrospective denials for services that meet the prudent layperson definitions (e.g., to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room)~~

v.✔ the right to access emergency services without prior authorization

~~10.__ [Required for MCOs] Procedures for obtaining non-covered or out-of-area services.~~

~~11.__ [Required for MCOs] Any special conditions or charges that may apply to obtaining services.~~

~~12.__ [Required for MCOs and PIHPs] The right to obtain family planning services from any Medicaid-participating provider~~

~~13.__ [Required for MCOs] Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider.~~

~~14.__ [Required for MCOs] Charges to enrollees, if applicable.~~

~~15.__ [Required for MCOs] Procedures for changing primary care providers.~~

~~16.__ Procedures for obtaining mental health, substance abuse, and developmental disability services.~~

~~17.__ Procedures for recommending changes in policies or services.~~

18.✔ The covered service area.

19.✔ Notification of termination or changes in benefits, services, service sites, or affiliated providers (if the enrollee is affected). Notices are provided in a timely manner.

The RFP2000 states:

"The contractor shall provide written notification about the Mental Health Capitation and Managed Care Program to all Medicaid recipients enrolled in the Program. Written notification shall include information on the following:

- *consumer rights, including the right to:*
  - ✓ *prompt notification of termination or changes in services or providers."* [107]

~~20. A description of new technology or new technology acceptance policies which are included as covered benefits.~~

~~21. Enrollees' right to obtain information about the MCO/PIHP, including information standards, utilization control procedures and the financial condition of the organization.~~

~~22. Other (please describe):~~

III. Enrollee Rights

Previous Waiver Period

~~**a.** During the last waiver period, the requirements for enrollee rights operated differently than described in the waiver governing that period. The differences were:~~

Upcoming Waiver Period -- For items a. through n. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

[107] *RFP2000 Section III-77. Attachment A.II.e.2.*

Please check any of the processes and procedures in the following list the State requires to ensure that contracting ~~MCOs~~/PIHPs protect enrollee rights. The State requires ~~MCOs~~/PIHPs to:

a. ✔ Have written policies with respect to enrollee rights.

b. ✔ Communicate policies to enrollees, staff and providers.

c. ✔ Monitor and promote compliance with their policies by staff and providers.

d. ✔ Ensure compliance with Federal and State laws affecting the rights of enrollees such as all Civil rights and anti-discrimination laws.

e. ✔ Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

f. ✔ Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

g. ✔ Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

~~**h.** Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.~~

i. ✔ Ensure that each enrollee has the right to refuse care from specific providers.

j. ✔ Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws.

k. ✔ Comply with requirements of Federal and State law with respect to advance directives.

*The PIHPs will provide adult enrollees with written information on advance directives policies, including a description of the applicable State law.***

l. ✔ Have specific written policies that allow enrollees to receive information on available treatment options or alternative courses of care, regardless of whether or not they are a covered benefit.

m. ✔ Allow direct access ~~to specialists~~ for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children)

In addition to providing Mental Health benefits to the general Medicaid population, the contractor is require to meet the needs of those consumers who have a severe and persistent mental illness (SPMI). Throughout most of the program, authorization for services to these consumers is done for a period of six to twelve months or more.

Since the start of the program in 1995, this special population has been the focus of significant service and program expansion. The State continues to support and evaluate the contractors' ability to create appropriate services for these consumers and will continue to evaluate the contractors' actions towards implementing a Recovery Model for those consumers who need this kind of service.

The RFP2000 was also written to maximize consumer choice and to increase the consumer's options in seeking services from a variety of providers.[108]

~~**n.** Other (please describe):~~

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

~~**a.** During the last waiver period, the State monitored compliance with enrollee information and rights differently than described in the waiver governing that period. The differences were:~~

[108] *RFP2000 Section III-79. Attachment A.II.e.2.*

b. ✔ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring ~~MCO~~/PIHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint].

The State has monitored enrollee information and rights documents during the past waiver period by following the conditions outlined in RFP2000 which requires contractor to submit all enrollee information to the State for approval prior to distribution.[109]

During the past waiver period the Program Quality Team has also monitored client rights notification through an annual medical chart audit. The results show that 90% of consumers sampled had acknowledged in writing that they received copies of their rights. [110]

Upcoming Waiver Period -- For items a. through d. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

~~**a**.___ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PIHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.~~

b. ✔ The State will approve enrollee information prior to its release by the ~~MCO~~/PIHP.

c. ✔ The State will monitor ~~MCO~~/PIHP enrollee materials for compliance in the following manner (please describe):

The State will monitor enrollee materials through provisions of the contract requiring State approval of all documents prior to their being sent to consumers. The State will also require the contractor

[109] *RFP2000 Section III-77. Attachment A.II.e.2.*
[110] *Chart Based Outcome Protocol Report FY01 and FY02*

to submit any revisions of these materials to the State for approval.[111, 112]

d.✔ The State will monitor the ~~MCO~~/PIHPs compliance with the enrollee rights provisions in the following manner (please describe):

The State will review and approve all material sent regarding consumers rights.

"…consumer rights, including the right to:

- *be treated with dignity and respect;*
- *participate in service planning;*
- *receive written information on available services and network providers;*
- *choose a provider from the provider network;*
- *request that a specific provider be considered for inclusion in the network;*
- *receive a second opinion;*
- *confidentiality;*
- *refuse treatment, except as provided by law;*
- *receive copies of clinical records and service plans;*
- *have an independent advocate;*
- *file a complaint;*
- *available and accessible covered services when medically necessary, including availability of appropriate care 24 hours a day, 7 days a week for urgent and emergent conditions;*
- *receive culturally appropriate and competent services from participating providers;*
- *interpreter services for consumers with communication disabilities or for non-English speaking consumers when such an interpreter is necessary in order to render effective communication in connection with the provision of covered services;*
- *receive from the consumer's provider, in terms that the consumer understands, an explanation of her/his complete condition, recommended treatment, risks of the treatment, expected results and reasonable alternatives. If the consumer is not capable of understanding the information, the explanation shall be provided to the consumer's biological, adoptive or foster parent, guardian or*

[111] *RFP2000 Section III-77. Attachment A.II.e.2.*
[112] *RFP2000 Section III-25.A. Attachment A.II.e.2.*

designated representative, and documented in the consumer's clinical record;

- *prompt notification of termination or changes in services or providers;*
- *express an opinion about the contractor's services to regulatory agencies, legislative bodies, or the media without the contractor causing any adverse effects upon the provision of covered services; and*
- *any other rights guaranteed by statute or regulation…"* [113]

[113] *RFP2000 Section III-77. Attachment A.II.e.2.*